DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHRYSALLIS INC

PAGE

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	r of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0.0938-03 survey
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			LETED
		09G161	B, WING		05	/02/2008
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CHRY\$A	LLIS			65 FIRST STREET, SE ASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETI DATE
W 000	INITIAL COMMEN	TS	w 000 l			
W 102	30, 2008 through N process was utilize clients was selecte of six males with m disabilities. The su observations in the programs, interviev including unusual in The findings of the facility failed to be i Conditions of Partic	survey revealed that the sompliance with the sipation in Governing Body, and Facility Staffing.	W 102		7008 JUN 13 P 3: 10	DETACTIVE HE ALL
	body and managen	sure that specific governing nent requirements are met. s not met as evidenced by:		W 102 In answer to W 102, the factories and adopts the responses to W W 149, W 114, W 120, W	d 104(3),	On-goin
. !	Surveyor: 16663 Based on observati review, the facility for the facility for the facility for the facility experating direction failed to ensure that facord was signed in the facord was signed.	ons, interviews, and record alled to ensure that governing ! xercised general policy and over the facility (See W104); t each entry into a client's and dated (See W114); and t outside services met the	:	and W 195. The Governing Body will a aggressively monitor the st work performances and the operations of the facility to prevent a repeat of the cor in W 102	more aff	
!	in the Governing B	e systemic practices resulted ody's failure to provide atment services and maintain				
	DIRECTOR'S OR PROVID		<u> </u>	ን፣ ፐ LE		(X8) DA⊤E

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

06/12/	2028 20:54 3	018536756	CHRY:	BALLIS INC	PAG	
		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 05/27/2008 RM APPROVED IO: 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		09G161	B. WING		0.5	://2/00
NAME OF	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	1 02	5/02/2008
CHRYSA	<u>. </u>			3765 FIRST STREET, SE WASHINGTON, DC 20020		•
(X4) ID PREFIX TAG	¡ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 102	Continued From page	ge 1	W 102		18, 1	
	· W195)	nd safety. (See W122 and		:		;
W 104	i 483.410(a)(1) GOVI !	:	W 104			1
;	The governing body budget, and operating	must exercise general policy, and direction over the facility.		: !		<u>'</u>
:	Surveyor: 16663	not met as evidenced by:		W 104		:
:	review, the facility's monitor and/or revise ensure the health are	Governing Body failed to entry its operation directions to end safety of the clients, for six end #4, #5 and #6)		As answer to W 104, the flatereby cross-references adopts the answers to W 14 W 189.	and	06-10-2008
	The findings include			The DON will continumnitor the nurses'	ue to	
		dy failed establish and/or nat ensured the client's health 149)		performances to ensure concompliance with all med administration policies.	isistent	06-16-2008
:	effectively trained to	dy failed to ensure staff were imanage each client's ors including the use of ions. (See W189)		The Governing Body will that all staff is re-trained follow up re-training (60-9	d with 0 days	09-05-2008
;		rning body failed to ensure is "Medication Disposal"		after 1 st session) in con areas. Supervising staff v required to provide job p monitoring to assess carry-c	will be ractice	i
;	revealed Client #2 w Chlorpromazine HCI and Topamax by the	ril 30, 2008 at 5:38 PM		information and procedure reflect current policies of organization.	es that	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/02/2008 09G161 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3765 FIRST STREET, SE **CHRYSALLIS** WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 104 W 104 : Continued From page 2 give Client #2 his medications (tablets) that the client sometimes would slap the medication cup from her hand. When the nurse attempted to give the client the medication. Client #2 slapped the medication cup from the the nurse's hand, spilling the tablets on the floor. The nurse was then observed to pick up the spilled tablets and administered Client #2 replacement medications. At 5:51 PM, the nurse disposed of the spilled tablets by placing the medications in the trash in the nurses' station. The trash bag was immediately taken outside and disposed of in the facility's external garbage receptacle. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's "Medication Disposal" policy on May 2, 2008, indicated that contaminated single dose drugs should be disposed of utilizing a witness method. The drug should be "flushed down the drain" documented and a witness should sign off indicating the event was observed. At the time of the survey, the facility failed to ensure its medication destruction policy had been implemented as outlined. W 110 483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that includes a separate record for each client. This STANDARD is not met as evidenced by: Surveyor: 16663 Based on interview and record review, the facility failed to maintain a completed and comprehensive medical assessment on file, for one of the three clients (Client #2) included in the sample.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		& MEDICAID SERVICES		U TIPLE CONCTRU	ICTIÓN	(X3) DATE	SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		09G161	B. WING			05/	02/2008	
NAME OF P	ROVIDER OR SUPPLIER		1	3765 FIRST ST	S, CITY, STATE, ZIP C TREET, SE DN, DC 20020	ODE		
				•	OVIDER'S PLAN OF CO	ORRECTION	· (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	: 1D PREF TAC	XIX (EACH	CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY	IN SHOULD BE E APPROPRIATE	COMPLETION DATE	
W 110	Continued From pa	age 3	W	110				
	The finding include	:5:	; ; ;	W 110			!	
· · · · · · · · · · · · · · · · · · ·	The facility failed to assessment was a evidenced below:	o ensure a complete medical vailable for review as		follows	nt # 2 medical as	ssessment was		
W 114	Review of Client #2's medical record on May 2, 2008, at 12:18 PM revealed a medical assessment dated November 8, 2007. Further review of the client's medical assessment revealed that it had not been signed or dated by the Primary Care Physician (PCP). Interview with the facility's Registered Nurse on May 2, 2008, revealed that some pages were missing from the assessment. At the time of the survey, there was no documented evidence that the client's medical record was maintained. 483.410(c)(4) CLIENT RECORDS		: : : : :	monito and si This en The I monito compli	pulled during other third part monitoring visits prior to the survey and subsequently incorrectly filed. This error was corrected on 5/03/03. The DON and the QMRP with monitor to ensure consister compliance with proper filing procedures.			
	Any individual who record must make	makes an entry in a client's it legibly, date it, and sign it.					; ;	
	Surveyor: 17620 Based on interview failed to ensure that record was signed	is not met as evidenced by: v and record review, the facility at each entry into a client's and dated, for one of three included in the sample.	; ·					
	The finding include	9 s:		,			,	
		emedication administration on :33 PM revealed the client was nedication	5	!				
	(Carbidopa/Levodo April 2008 Physicia	opa), Review of Client #1's an's Orders (POS) on May 2, revealed an order for	:				i	
L	·	C. 1. 5. 21 TO 21 TO		Facility ID: 09G16	61	If continuation s	heet Page 4 of 4	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	IÇIES M	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		= CONSTRUCTION		LETED
		09G161	B. WIN	IG		05	/02/2008
NAME OF PROVIDER OR CHRYSALLIS	SUPPLIER			376	ET ADDRESS, CITY, STATE. ZIP COD 5 FIRST STREET, SE SHINGTON, DC 20020	ਰ	
COERTY (FACH	DEE)CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
be applied review of notation "Erythromy notation for the do medication time, and the time of the notation W 120 483,410(c) OUTSIDE	cin Ophthat to each the POS D/C'd" way in order alled to be at made alled to be at made and the surron made and data (3) SEFE SOURC by must a	halmology 5mg/gm ointment to eye every evening. Continued revealed the hand written as documented adjacent to the r. It should be noted that e signed or dated by the the notation. Additionally, the n area designed on the form tion of discontinued area made provision for date, initials to be documented. At vey, the facility failed to ensure on Client #1's April 2008 POS ated.		114	As answer to W 114, the says follows: The nurse has been insreview all physician or proper signature and day MD must sign and do notation that the MD maphysician orders and medical records. The more aggressively monitin clients' records to consistent compliance recording procedures.	tructed to orders for ting. The ate every kes on the in the DON will tor entries to ensure	06-10-2008
Surveyor: Based on review, th services r (Client #1 The findir The facilit program a with his p Interview 2008 at 1 drops who	16663 observa e facility met the n) include ty failed t administe hysician's with the 1:25 AM en neede	o ensure that Client #3's day ered medications in compliance					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/S IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE \$	URVEY
	09G161		B. WING		05/0	2/2008
NAME OF P	ROVIDER OR SUPPLIER		37	EET ADDRESS, CITY, STATE, ZIP 65 FIRST STREET, SE ASHINGTON, DC 20020	CODE	
(X4) ID PREFIX TAG	: (EACH DEFIGIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
W 120	Continued From pa		W 120			
	indication to the sta pain. Whenever the aforementioned be	bjects out of his way, as an aff that he was experiencing be client exhibited any of the haviors, the day program staff urse and the ear drops would				1
	record on May 1, 2 order dated May 2 physician's orders, Aurodex drops" to for day program" (see Continued interview verified that Client as needed for pain further verified thro	3's day program's medical 008, revealed a physician's 007. According to the Client #3 was prescribed both ears twice daily split one start date April 26, 2007). w with the day program's nurse #3 only received the ear drops. The nurse's statement was ough review of the day on Administration Records				
	months of June 20 failed to provide ev	1008. The MARs for the 107 through February 2008 ridence that the client received daily basis as ordered.				
	ensure Client #3 re	survey the facility failed to eceived medication in he physician's order.			·	:
	program implemer	o ensure Client #1's day nted the client's Behavior ') and failed to intervene in the fihead slapping.				
	A. The facility faile was implemented	ed to ensure Client #1's BSP at the day program.				
	! 2008 at 12:01 PM ! intermittently grabl	ent #1's day program on May 1, revealed the client ping the staff member's lower t) while the staff member was			,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHRYSALLIS INC

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	TO ECID MEDICADI	E & MEDICAID SERVICES			OWR NO	<u>. 0938-0391</u>
CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING				
	09G161		B. WING		05/0	2/2008
NAME OF PI	ROVIDER OR SUPPLIER		376	ET ADDRESS, CITY, STATE, ZIP CODE 15 FIRST STREET, SE ASHINGTON, DC 20020		
				PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX : TAG ;	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION
W 120	Continued From p	age 6	W 120			:
	engaging the clien (sewing). The sta client likes to touch	at and class in a craft project aff member revealed that the h. At approximately 12:10 PM, as overheard telling Client #1 to	,			
	staff member on Mascertain if the click program. The state had a BSP and program the plan (last revi	ducted with the day program's May 1, 2008 at 12:26 PM to ent had a BSP at the day iff member revealed the client oduced the plan for review. ised on February 1, 2007) wing a program goal:	:			
	others more than	frain from tapping or grabbing 3 times on the monthly average npling period for 3 consecutive				;
:		of the plan revealed iding the following:				·
	Staff should shake pats on the back of These contacts sh	e [Client #1's] hand or give him or shoulder every 5-7 minutes.				
	If [Client #1] taps participant, he sho	on a staff member or program ould be redirected to an activity.				
:	. PM and 12:34 PM	I that observation between 12:01 I evidence that the trategies were implemented.				
		ed to ensure the day program nt #1's behavior of head	; ; ;			
	Observation at Cl 2008 at 12:05 PM	ient #1's day program on May 1, l, revealed Client #1 hit the left	·			: _:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
SENTERS FOR MEDICARE & MEDICARD SERVICES

DEPARTMENT OF	HEALTH	AND HUMAN SERVICES		,		APPROVED 0, 0938-0391
		& MEDICAID SERVICES	T	E CONSTRUCTION	(X3) DATE	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		09G161	B. WING		05/	02/2008
NAME OF PROVIDER OR S	UPPLIER		370	ET ADDRESS, CITY, STATE, ZIP CODE 55 FIRST STREET, SE' ASHINGTON, DC 20020		
PREFLY (EACH D	EFICIENC'	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERÊNCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
a grunting	head wit sound.	h his left hand and then made At 12:06 PM, the client was	W 120	W120 C The QMRP will meet w	eith day	
At 12:10 P head with his left han face (with his left was with his lef	M, Clien his left ha d as it wants thum bbserved thand a	t #1 was observed to hit his and and then began to shake as positioned in front of his b closest to his nose). The d to intermittently hit his head to 12:15 PM, 12:16 PM, 12:18	:	program on 6/09/2008 to and update their protoc managing client # 1 cloth of behavior in a safe and manner.	review col for chewing	06-09-2008
Interview wastaff members ascertain if program. A #1 had a B behaviors astaff members with the behavior of the	PM, 12:28 PM and 12:34 PM. It should be noted that staff was not observed to intervene. Interview was conducted with the day program's staff member on May 1, 2008 at 12:26 PM to ascertain if the client had a BSP at the day program. According to the staff member Client #1 had a BSP that addressed the client's behaviors of grabbing others. Additionally, the staff member revealed that the client had a behavior of hitting himself. Review of the plan			The facility hence forth w aggressively monitor the client # 1 and indeed the clients of the facility received their day programs.	services ne other	On-going
staff member program of tapping/gram revealed the on the self. At the time ensure the	per's sta ojective abbing b lat base -injuriou of the s day pro	bruary 1, 2007) verified the ternent and documented a that addressed the client's ehavior. The plan further line data was being collected is behavior of head-slapping. urvey, the facility failed to gram intervened in the client's ed head slapping behavior.				; ;
implement Client #1's Observation 2008 at 12 long piece	ed/deve cloth ch in at Clie :06 PM, of cloth	ed to ensure the day program doped a protocol to address ewing behavior. ent #1's day program on May 1, revealed the client pulling a (approximately 1" to 1 1/2" in gth) from his mouth, the client				:

Facility ID: 09G161

then placed it on the table in front of him. At

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OMB NO. 0938-03
XZ) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	
R WING .	25/20/2005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		200464	B. WING		05/	02/2008
		09G161	<u> </u>	TATE TIP CODE		02/2008
CHRYSA	PROVIDER OR SUPPLIER		3769	ET ADDRESS, CITY, STATE, ZIP CODE 5 FIRST STREET, SE	i	
			VVA	SHINGTON, DC 20020		
(X4) ID PREFIX YAG	(EACH DEFICIENC)	ATEMENT OF DEFICIÊNCIÉS Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 120	Continued From pa	age 8	W 120	,		(
	•	1 was observed to pick the				:
		able, briefly held it, and then	!			1
		ne table when the staff member				1
		ne wanted to participate in the				
		ng). At 12:17 PM, the client	i			:
		ck the cloth up from the table,				
		ith, and then put it back on the	·			
		as neither observed to wash	·			İ
		the table observed to be				
	: cleaned.		!			!
	:					
	i Interview was cond	lucted with the day program's				
		lay 1, 2008 at 12:26 PM to				
		nt had a BSP at the day				
		ig to the staff member Clieпt				}
		addressed the client's	į			
	behaviors of grabb	ing others. Additionally, the 🔠	:			j
		aled that the client had a				
	behavior of hitting I	himself. Review of the plan	1			
	(last revised on Fel	bruary 1, 2007) verified the 💎 🖠	:			
		tement and documented a 💎 🗀	:			
	program objective	that addressed the client's				
	tapping/grabbing b	ehavior. It should be noted 🔠	•			•
	that the cloth chew	ing was not addressed.				;
	I	l				!
		I's residential records on May 📑				i
		nately 7:40 PM revealed the				i .
		ard Procedure" dated April 10,	,			
		ed the client's clothe tearing				Ĭ
	!	ng to the documented	;			į
	procedure in the se					:
		/Human Rights Solution,"				
		a "long-standing deeply	1			
		or" of chewing. The plan	:			
		d that the "chewing has never	:			
		danger to [Client #1], there	•			}
		es when people have tried to	-			
		away from him. Nevertheless,				
	, there could be an c	ongoing risk of germs and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHRYSALLIS INC

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FORM APPROVED
OMB NO. 0938-0391

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO	0 <u>. 0938</u> -0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G161	B. WING		05/	02/2008
	AME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
W 120	Continued From pa	age 9	W 120	o [‡]	·	!
	inappropriate social been developed in clean squares of clean squares and that is, munched up	erty destruction issue, and the al stigma. A compromise has which [Client #1] will be given loth to chew on during his and when these get chewed up and withered looking, he will nge these for fresh clean				
	entitled, "Sucking." Client #1 was to be on that were "at lead pull them out of his resists giving one undocumented that, "clean cloth square away and [Client #1 one. When he given new one, staff should fifth time he exchart for a new one, staff edible reward, that the time of the survithe day program deactive protocol that management of Client safe and sanitary management of Client #1 one.		W 122	2		
:	This CONDITION is Surveyor: 17620 Based on observations	is not met as evidenced by: ion, interview and record failed to ensure each client's				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE : COMPL	
		09G161	B, WING_		05/	02/2008
NAME OF	PROVIDER OR SUPPLIER		37	EET ADDRESS. CITY. STATE, ZIP C 765 FIRST STREET, SE /ASHINGTON, DC 20020		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX : TAG :	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
W 124	parents/guardians vincidents [See W14 and procedures that safety [See W149]; injuries of unknown abuse were reported ensure all allegation unknown source we. The effects of these in the failure of the fensure their health at 483.420(a)(2) PROTRIGHTS The facility must ensure the facility parent (if the client is of the client's medical and behavioral status treatment, and of the Surveyor: 17620 Based on interview afailed to ensure their hegal guardian to medical condition, destatus, attendant risk to refuse treatment, 1 (Clients #1 and #2) in The finding includes: 1. Review of Client #	e W130]; failed to ensure were notified of serious [48]; failed to implement policies at ensured clients' health and failed to ensure that all a source and allegations of ed [See W153]; and failed to ensure and injuries of ere investigated [W154]. E systemic practices resulted facility to protect its clients and and safety. TECTION OF CLIENTS sure the rights of all clients. It is a minor), or legal guardian, eal condition, developmental ensure attendant risks of eright to refuse treatment. E not met as evidenced by: and record review, the facility rights of each client and/or to be informed of the client's evelopmental and behavioral its of treatment, and the right for two of the three clients included in the sample.	W 124	W 122 The facility has always consistently been protectients and ensuring the and safety. The facility parents/guardians of serincidents as required by facility's incident manapolicy. Please refer to runder referenced tag no W148, W149, W153 and	cting its cir health notifies rious the gement responses s: W130,	

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DEPAR	TMENT OF HEALT	H AND HUMAN SERVICES				PRINTE FOR	D: 05/27/200
STATEMEN	TO FOR DEFICIENCIES	& MEDICAID SERVICES	~			OMB N	0.0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		202404	e. Wil	NG		}	
NAME OF	150V/DED OD OVERVIE	09G161				05	/02 <u>/</u> 2008
VAME OF I	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
CHRYSA	ALLIS	·		370	65 FIRST STREET, SE ASHINGTON, DC 20020		
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	medical appointment that an additional 5 10 mg dose did not Continued review of 2008 at 3:39 PM revisive that an additional 5 10 mg dose did not Continued review of 2008 at 3:39 PM revisive that the reveal with Diazepam 10 m Additionally, the she could not be completed that the sed verified that the sed verified that the test to the client's inability requirements for the linterview with the factories and habilitative allowed that the client that a legal statement was verified that the client the client had a legal statement was verified that the client the client was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client that a legal statement was verified that the client th	2008) for the client to receive mouth one hour before a nt. The order further indicated mgs may be given if the initial sedate the client enough. Client #1' s record on May 2, realed a neurology consult 2008. According to the client had a MRI of his 5, 2008. The consultation and that the client was sedated any one hour before the MRI et revealed that the MRI ted because the client would test. Interview with the facility (RN) on May 2, 2008, ation was given and further could not be conducted due ity to comply with the	W	124	The facility protects and ensinghts of all its clients. As response to W 124, the facility as follows: Client # 2 has a father involved in his life. Client father has actively participate psychotropic medication rechis son a number of times and informed of the medications, side effects of the medication in managing client # 2 behavior the facility has additional review of psychotropic/sedation me information system and henceforth more aggressively and obtain written, separate from parents/legal guardians use of medications, in sedations when needed for	who is t # 2's d in the view of I he was risk and as used ors. made its dication will inform consent on the cluding critical scluding RP will lical to to the lical to the li	06-18-2008 On-going
1	granting , refusing a medical treatments; han medicaland r	acity on his own behalf in : nd/or withdrawing consent to : regarding treatments other lie does not have the capacity hower of attorney." At the			An informed consent form he created to ensure a documentation of this process.	ргорег	:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

W 124 Continued From page 12 time of the survey, the facility failed to provide evidence that Client #1's legal guardian was informed or the sedation prior to its use. 2. The facility failed to provide evidence that informed consent was obtained from Client #2 and/or his legal guardian for psychotropic medications. Observation of the evening medication administration on April 30, 2008 at approximately 5:38 PM revealed Client #2 received medications including Chlorpromazine 200 mg, Naitrexone Hydrochloride 50 mg. Topamax 100 mg, and Topamax 200 mg Interview with the medication nurse during the medications were used to address the client's behaviors. Interview with the House Manager on April 30, 2008 at 10:14 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The House Manager's statement was verified on May 2, 2008 at 2:13 PM through review of Client #2's psychological assessment dated November 14, 2007. According to the assessment, Client #2' does not evidence the decision making capacity on his own behalf in granting refusing, and/or withdrawing consent to medical treatments; regarding type and place of residence, regarding type and place of residence.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Chrysallis 3765 First Street, SE WASHINGTON, DC 20020			09G161	B. WING		05/	2/2008
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 124 Continued From page 12 time of the survey, the facility failed to provide evidence that Client #1's legal guardian was informed of the sedation prior to lts use. 2. The facility failed to provide evidence that informed consent was obtained from Client #2 and/or his legal guardian for psychotropic medications. Observation of the evening medication administration on April 30, 2008 at approximately 5:38 PM revealed Client #2 received medications including Chlorpromazine 200 mg, Naltrexone Hydrochloride 50 mg, Topamax 100 mg, and Topamax 200 mg Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Interview with the House Manager on April 30, 2008 at 10:14 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The House Manager's statement was verified on May 2, 2008 at 21:3 PM through review of Client #2's psychological assessment dated November 14, 2007. According to the assessment, Client #2' does not evidence the decision making capacity on his own behalf in granting refusing, and/or withdrawing consent to medical treatments; regarding type and place of residence, regarding type and place of residence.			10	376	55 FIRST STREET, SE	DE	
time of the survey, the facility failed to provide evidence that Client #1's legal guardian was informed of the sedation prior to its use. 2. The facility failed to provide evidence that informed consent was obtained from Client #2 and/or his legal guardian for psychotropic medications. Observation of the evening medication administration on April 30, 2008 at approximately 5:38 PM revealed Client #2 received medications including Chlorpromazine 200 mg, Naltrexone Hydrochloride 50 mg, Topamax 100 mg, and Topamax 200 mg, Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Interview with the House Manager on April 30, 2008 at 10:14 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The House Manager's statement was verified on May 2, 2008 at 2:13 PM through review of Client #2's psychological assessment dated November 14, 2007. According to the assessment, Client #2' does not evidence the decision making capacity on his own behalf in granting refusing, and/or withdrawing consent to medical treatments; regarding treatments other than medical, regarding type and place of residence, regarding	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETION DATE
finances; and/or regarding life planning; and he does not have the capacity to execute a durable power of attorney." Interview with the QMRP on May 2, 2008 revealed Client #2 did have family involvement (father) however, at the time of the survey there was no documented evidence that		time of the survey evidence that Clier informed of the se 2. The facility fails informed consent and/or his legal gui medications. Observation of the administration on 25:38 PM revealed including Chlorpro Hydrochloride 50 r. Topamax 200 mg. nurse during the more vealed the afore used to address the linterview with the 2008 at 10:14 AM have the capacity use of medications House Manager's 2, 2008 at 2:13 PM psychological asse 2007. According to "does not evidence on his own behalf withdrawing conservegarding treatmer regarding type and finances; and/or redoes not have the power of attorney.' May 2, 2008 reveal involvement (fathe	the facility failed to provide at #1's legal guardian was dation prior to its use. In the facility failed to provide at the topic from the twas obtained from Client #2 ardian for psychotropic I evening medication April 30, 2008 at approximately Client #2 received medications mazine 200 mg, Naltrexone mg, Topamax 100 mg, and Interview with the medication mentioned medications were declient's behaviors. House Manager on April 30, revealed that Client #2 did not to give informed consent for the statement was verified on May I through review of Client #2's assment dated November 14, to the assessment, Client #2 the decision making capacity in granting refusing, and/or and to medical treatments; and he capacity to execute a durable interview with the QMRP on led Client #2 did have family r) however, at the time of the	W 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/27/2008

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>- 1 </u>	2000
CHRYS	ALLIS				3765 FIRST STREET, SE WASHINGTON, DC 20020		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		上			
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W 124	Continued From pag		W		4		
•	the client had a lega	l guardian.			:		i
	was informed of the determine if consent medication. The QN consents obtained fr in his record. However record and further diffailed to provide evide consent (written and obtained prior to the medications. At the facility failed to provide consent was obtained legally authorized reppsychotropic medical	authorized representative psychotropic medications to was obtained for the IRP revealed that there were om Client #2's father located yer, review of Client #2's scussion with the QMRP ence that any type of for informed) had been aforementioned psychotropic time of the survey, the de evidence that informed d from Client #2 and/or presentative for his tions.	W 1	30	· · · · · · · · · · · · · · · · · · ·		
;	Therefore, the facility treatment and care of	ure the rights of all clients. must ensure privacy during personal needs. not met as evidenced by:			In response to W 130, the says that it ensures privacy of its clients, including client # 1 during all treatments and of personal needs. Further,	f all of and 3,	
:	Surveyor: 17620 Based on observation each client's right to p clients (Clients #1 and The findings include:	i, the facility failed to ensure rivacy, for two of the three £3) included iπ the sample.			[1.] Staff is instructed to a client # 3 while using the babecause client # 3 fainted while the bathroom in 20007 and was to hospital, treated and dischar However, the facility will of further staff training on clients.	throom e using s taken ged. onduct	i
; •	4:36 PM revealed Clie	ucted on May 2, 2008, at ent #3 received staff at the bathroom. The client			further staff training on client rights and protection to en reasonable balance b	sure a etween	

was observed seated on the toilet with the

bathroom door opened. At the time of the survey,

monitoring client # 3 and the need to

protect his privacy at all times.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES			, 	FOR	D: 05/27/2008 MAPPROVED 0:0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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CHRYS			·	3	REET ADDRESS, CITY, STATE, ZIP CODE 765 FIRST STREET, SE VASHINGTON, DC 20020		
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W 148	2. Observation of C 5:46 PM, revealed (his buttocks exposed (pants down). Client Client #1 by escorting room through the direction of the aforementioned member assigned to #6 was assisting the member with a behat Client #2. At the time failed to ensure Client dressing. 483.420(c)(6) COMM CLIENTS, PARENTS The facility must notify parents or guardian of changes in the client limited to, serious illustration or unauthorized abset. This STANDARD is a Surveyor: 17620 Based on interview and failed to ensure parent of serious incidents, for (Clients #1 and #6) the The findings include: Interview with the facility with the facility with the facility must notify parents or guardian or unauthorized abset.	ensure the client's right to d during his personal care. lient #1 on May 1, 2008 at Client #1 was observed with d in the television room t #4's 1:1 attempted to assist g him from the television hing room (with his buttocks ent #4 accompanying them) ould be noted that at the time of observation, the staff work with Clients #1, #3 and QMRP and another staff vioral episode involving ent #1's right to privacy during at #1's right to privacy during the survey, the facility of any significant incidents, or se condition including, but not ess, accident, death, abuse, nice. Indirect the client's end and record review, the facility ents/guardians were notified out two of the six clients at resided in the facility.	W 1	48		nght to me, an d. The med to ergency or from action with the of a nin this sed his he staff members issues also be	06-05-2008
		HOLLOWING TONION OF		1			

PRINTED: 05/27/2008 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

3018536756

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION

OMB NO. 0938-0391 (X3) DATÉ SURVEY COMPLETED

09G161

IDENTIFICATION NUMBER:

A. BUILDING B. WING

05/02/2008

NAME OF PROVIDER OR SUPPLIER

CHRYSALLIS

STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE

WASHINGTON, DC 20020

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ΙĎ PREFIX TAG

W 148 ·

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**)

(X5)COMPLÉTION DATE

W 148

Continued From page 15

the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at ... 2:11 PM revealed the following:

- a. On December 31, 2007, staff reported that Client #1 had been taken to the emergency room due to prolonged diarrhea and some vomiting. The client was released on January 1, 2008 with a diagnosis of gastroenteritis. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed Client #1 had a legal guardian that was involved with his care. Continued review of the facility's incident reports failed to provide evidence that the client's legal guardian had been notified of the aforementioned incident.
- b. On September 12, 2007, staff reported that Client #1 was weak upon returning from a community outing at the day program. The client was sent via ambulance to the emergency room for evaluation. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed Client #1 had a legal guardian that was involved with his care. Continued review of the facility's incident reports failed to provide evidence that the client's legal guardian had been notified of the aforementioned incident.
- c. On December 31, 2007, staff reported that Client #6 was picked up from his day program and was unable to walk. Client #6 was subsequently taken to the emergency room to be evaluated. The client was treated for fatigue and was released on January 1, 2008. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed that Client #6 had a legal guardian and a mother that was involved in his care, Review of the facility's incident reports however, failed to provide evidence that the legal/quardian and

W 148

As response to W 148, the facility savs as follows:

The facility has always notified the parents /guardians and DDS case managers of any serious incident involving clients # 1 and # 6 as well as the other clients of the facility. The notification is always telephone and was not noted on the incident reports reviewed by the surveyor. This oversight is noted and will be avoided henceforth. All telephone notifications parents/guardians and Case Managers will be reflected henceforth on the file copy of the incident report in the home.

The QMRP will provide more oversight to the operations of the incident management coordinator. The CEO will more consistently supervise the QMRP to assure that all notifications to parents/ guardians and Case managers are documented in the file copy of the incident report the home to facilitate the implementation of the facility's incident management policy.

On-going

06-04-2008

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3LTR11

Facility ID: 09G161

If continuation sheet Page 16 of 44

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/27/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OM<u>B NO. 0938-039</u>1 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G161 05/02/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CHRYSALLIS 3765 FIRST STREET, SE WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 148 : Continued From page 16 W 148 mother were notified of the aforementioned incident. d. On October 25, staff reported that Client #2 "fell up the stairs to the doctor's office." Continued review of the report revealed the client was observed to hit his mouth on the cement and cracked his right front tooth. Interview with the QMRP on May 1, 2008 at 2:18 PM revealed that Client #2 had a father that was involved in his care. Review of the facility's incident reports however, failed to provide evidence that the client's father had been notified of the aforementioned incident 483.420(d)(1) STAFF TREATMENT OF W 149 W 149 CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the facility failed to establish and/or implement policies that ensured the client's health and safety, for two of the three clients (Clients #1 and #2) that resided in the facility. The findings include: 1. The facility failed to ensure the implementation of its "Incident Management" policy as outlined.

Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on May 1, 2008, beginning at 2:11 PM revealed the following:

CHRYSALLIS INC PAGE 06/12/2028 20:54 3018536756 PRINTED: 05/27/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 8. WING 09G161 05/02/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE CHRYSALLIS WASHINGTON, DC 20020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 149 | Continued From page 17 W 149 a. On October 22, 2007, staff reported observing an "abrasion or bruise" оп Client #1's left leg. W 149 b. On August 10, 2007, staff reported discovering a bruise on Client #2's right knee. The facility has always and consistently been protecting its c. On August 9, 2007, staff reported discovering clients and ensuring their health and a bruise on Client #2's left shoulder. safety. d. On November 12, 2007, the nurse reported [1.] The injuries listed in W. 149 that Client #1's lower lip was swollen. involve clients who are on BSP for self injurious behaviors. Client # 1 Continued review of the facility's incidents reports 06-04-2008 has a diagnosis of vertiligo, which failed to provide evidence that the results in occasional break up of skin. aforementioned incidents were reported immediately to the administrator or to other He is on medical treatment and officials in accordance with State law. monitoring for this problem. Client # Additionally, there was no evidence that the 2 was base-lined for abusing himself incidents that occurred on October 22, 2007 and which resulted in developing a BSP November 12, 2007, were investigated. targeting self injurious behavior in November, 2007. Interview with the QMRP on May 2, 2008 at 11:32 AM revealed that whenever an incident occurred The incident either the QMRP or the House Manager's (HM) management coordinator shall follow company was responsible for notifying the administrator policy and investigate all incidents of (also the Registered Nurse) Additionally, the On-going unknown origin: only the outcome of QMRP indicated that it was his responsibility to ensure the incident report was taken to the main investigation will determine office to the Incident Management Coordinator whether they are considered serious (IMC). reportable or reportable incidents.

Continued interview with the QMRP revealed that

the IMC was responsible for making a decision as

process.

Such investigation reports shall be

filed with the incident report and kept

in the facility record. The QMRP

maintain oversight in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 149	was three days) all review of an invest Review of the facili policy on May 2, 20 reportable incidents notification to be m Management Coordaministration. It is policy revealed that serious reportable hours of the incider discovered. Additionall investigations is (5) working days of the survey, the facili	ut the length of time (thought it lotted for the completion and tigation. ity's "Incident Management" 008 revealed that all serious is required immediate nade to the facility's Incident				
	Observation of Clie beginning at 4:44 P piece of cloth out of approximately 1" to length). After remothe client placed the located in the televithen observed to pion a green striped cobserved to pick the counter (located out ground, pick it up of on a striped chair in	d to ensure Client #1's was implemented as outlined. ent #1 on May 1, 2008, M revealed the client taking a of his mouth (cloth was on 1 1/2 in width and 6" in oving the cloth from his mouth, e cloth on the green chair ision room. The client was lick the cloth back up and put it chair. The client was then the cloth up and place it on the utside of the kitchen), touch the off of the counter, and place it in the TV room. At 5:01 PM, erved to place the cloth back in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIÇATION NUMBER:		LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	cloth out of his more television room. The pick the cloth up are (located outside of the cloth up from the ground. After picking the client was observed to put the piece of cloth to back into his more observed to put the television room and mouth. It should be aforementioned ob assigned to work wassisting the QMRF with a behavioral elevision entitled, "Graphics Solution," Chewing to the dosection entitled, "Grights Solution," Chewing. The plan "chewing has never [Client #1], there has people have tried to from him. Neverthe ongoing risk of gere	#1 was observed to take the ath and put it on a chair in the ne client was then observed to not place it on the counter the kitchen). Client #1 picked ne counter and placed it on the right the cloth up from the floor, erved to tap the surveyor twice is cloth back into his mouth at PM, Client #1 was observed to the on the floor and then placed of the At 5:43 PM, Client #1 was elected to the cloth on the couch in the dithen put it directly into his is noted that at the time of the servations, the staff member pisode involving Client #2. 's record on May 2, 2008 at PM revealed the client had a re" dated April 10, 2007 that int's clothe tearing behavior. Incomented procedure in the isoal/Compromise/Human	W	149	W149 [2.] The facility shall in the "Standard Prodesigned for client 1 as The facility has a protoclient # 1 cloth chewing which the staff import However, the emergency created by client # 2 expressions.	written. ocol for behavior olements, situation explosive surveyor gned to material staff has how to cy in the it from a	06-16-2008 On-going
į	which [Client #1] wi cloth to chew on du	nise has been developed in Il be given clean squares of ring his relaxation times and ewed up that is, munched up					:

PRINTED: 05/27/2008 FORM APPROVED OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES_

(X3) DATE SURVEY WAY MULTIPLE CONSTRUCTION

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL ILDING	E CONSTRUCTION	COMPLI	
		. 09G161	B. WII	۷G		05/0	2/2008
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W 149	exchange these for continued review of entitled, "Sucking." Client #1 was to be on that were "at least pull them out of his resists giving one of documented that, "clean cloth square away and [Client # one. When he given new one, staff should for a new one, staff should for a new one, staff the time of the sund the time of the sund the consistent imples "Standard Procedus behavior by making the continue of the sund the sun	age 20 ag, he will be asked to fresh clean squares of cloth." of the plan revealed a section According to that section, e supplied cloth pieces to chew lest 6" X 6" so that staff could mouth if he starts to choke or up." The plan further once he has chewed on a for a while, it should be thrown 1] should be offered a new les up the old one and gets a lid verbally praise him. Every langes the old chewed up cloth of should also give him an is consistent with his diet." At vey, the facility failed to ensure ementation of Client #1's re" that addressed his tearing of certain he was provided with and sanitary cloths as	W	149			
	The facility must ermistreatment, neglinjuries of unknowr immediately to the officials in accordation established proceduries and the Surveyor: 17620 Based on interview failed to ensure the	rand record review, the facility at all allegations of and record were immediately	W	153			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 153	Continued From pa	ige 21	W 153	3		1
	accordance with Sta	ninistrator or to other officials in tate law, for two of the three		W 153		
	 clients (Clients #1 a sample. 	and #2) that included the		The administrator of t	he facility	
		İ		was immediately infor		:
!	: The finding includes :	\$:		the incidents involving	g clients # 1	
İ	Interview with the fa	acility's Qualified Mental		2 and 4 referenced as a		1
ļ	Retardation Profess	sional (QMRP) and review of		policy and procedure. the information was de-		
ļ		its reports and corresponding son May 1, 2008, beginning at		and on telephone as ar		06-04-200
i	2:11 PM revealed th			incidents occur. The in		
:	: - a. On October 22.1	2007, staff reported observing		to the administrator wa	as not	•
!	an "abrasion or brui	ise" on Client #1's left leg.		reflected on the incide		1
į	Continued review of	f the facility's incidents failed		reviewed by the survey		i
,	to provide evidence immediately to the a	that the incident was reported ' administrator or to other		facility has reviewed the		•
}	officials in accordan	ice with State law.	•	information system an changes.	d made	
	b. On August 10, 20	007, staff reported discovering		Henceforth, all incide		•
;	a bruise on Client #2	2's right knee. Continued		information given to the		:
;	review of the facility' evidence that the inc	's incidents failed to provide		administrator directly	and on	
1		cident was reported administrator or to other		phone will be noted on		
	officials in accordan			copy of the in incident	report as	
1	a On August 9, 200	AT staff rowaviad disapposing		additional note.		On-going
1	a bruise on Client #	07, staff reported discovering 2's left shoulder. Continued		The QMRP will more aggressively review all	t tu stakena	OII-80
!	review of the facility's	's incidents failed to provide		reports weekly to ensu		;
-	evidence that the inc	cident was reported		needed information are		
	officials in accordant	administrator or to other :		accordingly reflected o		1
	•			copy of incident report		
1	d. On November 12	2, 2007, the nurse reported				
		r lip was swollen. Continued s incidents failed to provide				
. (evidence that the inc	cident was reported		T.		•
įĪ	immediately to the a	administrator or to other				,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

CTATEME	NE OF OFFICIAL CONTRACTOR	A MEDICAID SERVICES			O <u>MB_</u> N	IO. 0938-039
AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE	E SURVEY PLETED
		000464	B. WING	· · · · · · · · · · · · · · · · · · ·		
NAME OF	PROVIDER OR SUPPLIER	09G161			0.5	5/02/2008
CHRYS			s	TREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE		
	···	<u>. </u>		WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	COMPLETION DATE
W 153	Continued From pag		W 15	3		
	officials in accordan	ce with State law.	• • • - •	~ i		•
	an "abrasion" on Clic review of the facility' evidence that the inc immediately to the a officials in accordance	dministrator or to other ce with State law.		W 154 The facility has always consistently been protection clients and ensuring their heat safety.	ng its	1 1
W 154	, provide evidence tha		W 154	He is on medical treatme	SSP for ent # 1 which of skin.	06-04-2008
	The facility must hav violations are thoroug	re evidence that all alleged ghly investigated.		monitoring for this problem. 6 2 was base-lined for abusing which resulted in developing targeting self injurious beha	himself a BSP	
:	Surveyor: 17620 Based on interview a failed to ensure that a	not met as evidenced by: and record review, the facility all injuries of unknown origin		November, 2007. Further, cl has a self-injurious behavior well.	ient # 4	
!	clients (Clients #1ar	stigated, for two of the six nd #4) residing in the facility.		coordinator shall follow co		On-going
	The findings include:			policy and investigate all inci- unknown origin, only the out		
	Retardation Profession the facility's incidents beginning at 2:11 PM a. On October 22, 20 an "abrasion or bruise Continued review of the facility of the facil	cility's Qualified Mental onal (QMRP) and review of seports on May 1, 2008, if revealed the following: 007, staff reported observing e" on Client #1's left leg, the facility's incidents failed that the incident had been	v	an investigation will de whether they are considered reportable or reportable in Such investigation reports s filed with the incident report a in the facility record. The	etermine serious icidents shall be and kept	

06/12/2028 20:54 3	018536756	CHR	RYS	SALLIS INC	PAG	E 25
DEPARTMENT OF HEALTH	H AND HUMAN SERVICES				PRINTE	D: 05/27/2008
CENTERS FOR MEDICARI	& MEDICAID SERVICES			•	FOR	(M) A IP PROVED
O TO TEMENT OF DEFICIENCIES	DEFICIENCIES Louis and a second					O. 0938-0391
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1		TIPLE CONSTRUCTION	(X3) DATE SURVEY	
		A. BU	ILDI	ING	СОМЕ	PLETED
	09G161	B. WI	NG.			
NAME OF PROVIDER OR SUPPLIER					05,	/02/2008
CHRYSALLIS			\$T	TREET ADDRESS, CITY, STATE, ZIP CODE		
J.M. TOALLIS				3765 FIRST STREET, SE		
(X4) ID . SUMMARY STA	TEMENT OF DEFICIENCIES		Ĺ,	WASHINGTON, DC 20020		
LUGERY (CACH DEFICIENCY	MUST BE PRECEDED by bury	ID PREFI	ſΧ	PROVIDER'S PLAN OF CORRECT	TION	(X5)
ING INCODE TORY OR E	SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE ROPRIATE	COMPLETION DATE
30/ 454				DEFICIENCY)		1
W 154 Continued From page	ge 23	W 1	154			!
;		** '	-	[] -		i
b. On November 12	2, 2007, the nurse reported					1
inal Client #1's lowe	Flip was swollen. Continued.					
leview of the facility	5 incidents failed to provide					!
evidence that the inc	cident had been investigated.			±		!
C On March 16, 20	3b _+_ee i					1
an "abrasion" on Clic	D8, staff reported observing in #4's left knee. Continued					
review of the facility	s incidents failed to provide					
evidence that the inc	sident had been investigated.			1		
W 158 483.430 FACILITY S	TAFFING	147.47		***************************************	•	
	i	W 15	58	W 158		
The facility must ens	ure that specific facility		į	İ		<u>'</u>
 staffing requirements 	are met.		ĺ	The facility ensures that st		:
ŧ	:		:	requirements are met by pro-	viding	
i This control to the			:	pre-employment training,	initial 0	6-16-2008
I INIS CONDITION IS	поt met as evidenced by:			hire mentoring on the job		1
Surveyor: 16663				subsequent in-service traini		•
review the facility fail	ns, interviews, and record			core service delivery	areas	
Client's active treatme	ed to ensure that each ent program was integrated.		·	specific to the individuals s		:
Coordinated and mon	itored by the Qualified					:
Mental Retardation P	rofessional (QMRP) [See		;	through out the year and ann		
W159]; failed to ensu	re that each employee was		ì	The QMRP shall more effec	_	\ .
provided with initial a	nd continuing training that			monitor the staff for their a	_	m-going
enabled the employed	e to perform his or her duties		,	to demonstrate the skills		. 1
effectively, efficiently,	and competently [See		:	techniques taught during		; <u> </u>
vv189);and failed to e	nsure staff were able to		;	actual job practice period		
to administes interest	s and techniques necessary			through the year. Staff re-tra		;
; client's behaviors [Se	tions to manage each		į	will be reflective of job pro-	actice	!
onem a penaviora (Se	E VV 193].		:	observations. Documentation		[
The effects of these s	ystemic practices resulted			all training efforts an		!
in the facility's failure	to provide adequate staffing			mentoring checklist shall		
to ensure continuous	active treatment services			maintained in the record	, 50	
1 111 4 4	·			manicallog ill life lection.		

[See also W122]

W 159 483,430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

and the protection of client's health and safety.

W 159

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

ATATEL		T MEDICAID SERVICES	 		- OMB WC	<u>/_U9</u> 38-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	SURVEY
		09G161	B. WING		05/	02/2008
CHRYSA	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C 3765 FIRST STREET, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 159	Continued From page	. !	W 159	9 W 159		
,	integrated, coordina qualified mental reta	treatment program must be tated and monitored by a ardation professional.		In response to W 159(facility hereby cross-rand adopts the answer	eferences	:
Surveyor: 17620 Based on interview and refailed to ensure that each program was integrated, or		ualified Mental Retardation		in W 120. In response to W 159(facility hereby cross-re and adopts the answer in W 189.	eferences	
:	The findings include 1. The QMRP failed services met the nee W120)	d to ensure that outside eds of each client. (See		In answer to W 159(3) hereby cross-reference adopts the answers con W 189.	es and	: :
; ; ;	2. The QMRP failed employee was provid training that enabled or her duties effective competently. (See V	ded with initial and continuing if the employee to perform his rely, efficiently, and		In answer to W 159(4) hereby cross-reference adopts the responses c W 249	es and	
	of demonstrating the necessary to adminis	to ensure staff were capable skills and techniques ster interventions to manage havior of clients (See W193).		In answer to W 159(5) hereby cross-reference adopts the answers con W 249.	es and	
	received continuous (See W196) 5. The QMRP failed the Interdisciplinary I client's Individual Pro	to ensure each client active treatment services, to ensure that as soon as Team (IDT) formulated each ogram Plan (IPP), clients active treatment, consisting		In answer to W 159(6) hereby cross-reference adopts the answers cor W 149.	es and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEME	NT OF DEFICIENCIES	LA MEDIONID SERVICES	····		OMB N	<u>0, 0938-039</u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		09G161	B, WING	3	05	/02/2000
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		PTDPCT ADDDESS COLUMN		02/2008
CHRYS	ALLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020	i	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	HOULD BE	(X5) COMPLETION DATE
W 159	Continued From page	de 25	W 15	50		<u> </u>
		ons and services, (See	, ,	W 189		1
	 provided with pieces 	to ensure Client #1 was of cloth that were safe and in the client's documented 9)		As answer to W 189, the facil as follows:		
W 189	483.430(e)(1) STAF	F TRAINING PROGRAM	W 18	onemiation and training by the	House	
	initial and continuing employee to perform	vide each employee with training that enables the n his or her duties effectively,		manager in the home duri absence of the QMRP due to There was no signature shee	illness.	
:	efficiently, and comp This STANDARD is	etently. not met as evidenced by:		subsequently returned to the and again gave training to clies	nt # 2's	
	Surveyor: 16663 Based on observatio	n, interview and record led to ensure that each		1:1 evening staff based on cli BSP and general job one Again, no signature sheet wa	ntation. s made	!
1	employee was provid training that enabled or her duties effective	led with initial and continuing the employee to perform his		to evidence this training. The conducted a BSP training on prior the hiring of client #	1/25/08 2's 1:1	
. !	competently, The findings include:	•		evening staff. The plan variange for a more compreteraining that will be conducted	hensive I by the	;
1	Client #2's 1:1 staff w	o provide evidence that as trained on his Behavior noluding the use of special		Behavior specialist for client 1:1 evening staff.	. # 2's	
,	techniques/intervention	ons to manage the client's		2. Both the QMRP and the manager have received instrand directions from the CEO to	uctions	:
• [PM revealed a 1:1 dir escorting Client #2_tc	1, 2008 beginning at 5:09 ect care staff (Staff #1) the facility's TV room. At			a and house	
1	oom directly behind s	ne sofa in the in the TV Surveyor A. At		3. Human Resources and the shall more aggressively mon	e CEO	
	approximately 5;26 Pl	M, Surveyor B observed		training documentations to		

CHRYSALLIS INC PAGE 06/12/2028 20:54 3018536756 PRINTED: 05/27/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB <u>NO. 0</u>938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G161 05/02/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE CHRYSALLIS WASHINGTON, DC 20020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 189 : Continued From page 26 W 189 that records are properly kept and Client #2 heading rapidly towards Surveyor A with available for inspections. both of his arms extended (Surveyor A's back was facing the client). Surveyor B assisted 4. The facility's CPI trainings are Surveyor A by moving Surveyor A out of the conducted by Department reach of Client #2. The client was observed to Disability Services (DDS) authorized be physically aggressive and began to yell and trainer. DDS suspended CPI training scream. in February, 2008, DDS has now Continued observation during the aggressive resumed the training, but the DDS episode revealed Client #2's 1:1 staff (Staff #1) tramer will not be available to train attempted to prevent the aggression towards staff until after November, 2008 06-16-2008 Surveyor A by pulling the client. Client #2 was when she will return from maternity then observed to head down the hallway towards leave. his bedroom, but prior to getting to the hallway, Client #2 hit Surveyor A. Afterwards, Client #2 5. As a result the aforesaid DDS CPI proceeded down the hallway with his 1:1 staff training schedule, client # 2 1:1 staff person holding onto his arm. At that time, the could not receive CPI training at time direct care staff person assigned to work with of the survey. Also the OMRP who Clients #1, #3 and #6 (Staff #2) and the Qualified Mental Retardation Professional (QMRP) were was trained could not re-train at the observed to assist in the intervention of Client time of the survey, and staff # 2 who #2's behavior. The three staff were observed to had received CPI training but needed have difficulty redirecting the client. They were to re-train and pass the test could not observed to restrain both of Client #2's arms for do that before survey. Copies of approximately three minutes. Once the client QMRP and staff # 2 last training appeared to be calm the staff escorted Client #2 documentations are hereby attached. outside of the facility. Interview with the QMRP on May 2, 2008 at 5:30 PM revealed that Client #2 had a Behavior Support Plan (BSP) that addressed behaviors of

self injurious behaviors, physical aggression (such as scratching and hitting people) and throwing objects. The QMRP's statement was verified on May 2, 2008 through review of Client #2's BSP dated November 17, 2007. According to the plan, in a section entitled "Intervention Procedures for Physical Aggression," the following procedures were to be implemented:

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PRINTED: 05/27/2008 FORM APPROVED ENTERS FOR MEDICARE & MEDICAID SERVICI OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G161 05/02/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE CHRYSALLIS WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 189 Continued From page 27 W 189 If [client's name] engages in aggression, he will be given the verbal directive, "Stop [client's name]." At the time of the observation, the three staff were not observed giving a directive for Client #2 to " stop." If [client's name] continues displaying aggressive behaviors staff should assume the "CPI Supportive Stance" as trained in the "Non-Violence Crisis Intervention Program." Interview was conducted with the QMRP on May 1, 2008 at 5:30 PM to ascertain information regarding which staff was trained on specialized techniques to manage inappropriate behavior (CPI Supportive Stance and Non-Violence Crisis Intervention Techniques). At the time of the survey, the facility failed to provide evidence that | the QMRP, Staff 1 and Staff 2 had been trained in the aforementioned techniques. It should be noted that during the observation there was no evidence that the staff addressing Client #2's behaviors assumed the supportive stance documented in the client's BSP. 3. Staff should remember to consider such things as personal space (remain about 1-3 feet away) and body posture/motion (keep your hands open and facing upward). At the time of the observation, the three staff were in close proximity of Client #2. Additionally, the staff's hands were not positioned as indicated in the aforementioned intervention. It should noted that all three staff were observed to restrain the i client's arms. 4. In the event that the behavior escalates, staff will utilize a block technique (learned in NVCI, see

instructors' Manual) to interrupt the behavior(s).

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	CIMB M	0. 0938 ₋₀₃₉
	,	DENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G161	B. WING		ł	
NAME OF	PROVIDER OR SUPPLIER	000101			05/	02/2008
CHRYSALLIS			37€	ET ADDRESS, CITY, STATE, ZIP CO 35 F IRST STREET, SE	ODE	
(X4) ID	SUMMARY STA	TEMENT OF ACCUMULATION	W/	SHINGTON, DC 20020		
PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(XS) COMPLETION DATE
W 189	Continued From page	ge 28	W 189			1
	At the time of the ob	servation, the three staff	VV 109			:
	were not observed to	o utilize/implement a block	:			1
	lechnique as recom	mended in Client #2's BSP.	ļ			
i	Note: During Client	#2's physical aggression	t [:
1	shizode tutée žťati A	VERE Observed to restrain the	1			1 1
i	clients arms for app	roximately four minutes (5.26				-
	PM - 5:30 PM). The	QMRP's was interview on	*			i
1	way 1, 2008 reveale	d that the facility failed to				
	provide evidence that	tt Staff 1. Staff 2. and thei	į			i
1	UMRP were trained	in the specialized techniques	. !			•
1	used to manage inat	Opropriate behaviors III	i			-
:	#2 was seeing at the	ed that on May 2, 2008, Staff	•			
1	of the facility's Assista	vork with Client #2. Review	i			
	interview with the QN	g record and continued	1			
	evidence that Staff 3	was trained to provide	!			:
	Non-Violence Crisis I	ntervention Program and/or				
	any other specialized	techniques to manage	į			. 1
	inappropriate behavio	or.				1
1		1				•
,	Additional interview w	vith the QMRP on May 1,	:			
	2008, at 5:30 PM rev	ealed Client #2's assigned	j			!
٠.	1:1 staff (Staff #1) ha	ad been employed at the				·
: 1	facility for less than a	month (since April 2008).	l i			
/	According to the QMF	RP, he trained the 1:1 staff			i	
	on Client #2's BSP, \	When requested to provide	ı		,	
	evidence of the training	ng he conducted with the 1:1		•		
1.5	stan, the QMRP tallet	to produce evidence of the	:			1
, c	aiorementioned traini Taining records on M	ng. Review of the facility's			:	
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֡֓֓֡֓֡	raining records on Mi revealed the last train	ay 1, 2008 at 6:25 PM, ing on BSP's was held on	;			
		ent #2's 1:1 staff was not	ì		:	
		g. It should be further	:		:	1
	noted that the training	sign in sheet failed to	;	·		i
<u> </u>	specifically identify wh	nich BSP's were reviewed.	İ			1
Ì	, , , , , , , , , , , , , , , , , , , ,				į	1
		nt #2's BSP on May 2, 2008 ititled, "Behavior History,"	•		i	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES	•		FOR	D: 05/27/20 MAPPROV
AND PLAN OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1		OMB N	<u>0.0938-03</u>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE	SURVEY LETED
		09G161	B. WING_		1	
NAME OF	PROVIDER OR SUPPLIER				05/	02/2008
CHRYSA			3	REET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020	1	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES				
PREFIX TAG	REGULATORY OR LS	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULDBE	(X5) COMPLETION DATE
	Continued From pag		W 189	1		
	According to that se	ection. Client #2 "has a history		W189		i
!	to needing behavior	[a] Support. He has for some	•			!
	, ome nad til statt st	Upport due to concerns		6. In answer to W 189 11, the	A . 114	•
;	i regarding intense ad	QQFessive and self-injurious)	some that Wilson stiant # 2	aculity	
Ī	penavior. According	g to MRDDA case manager	ļ	says that When client # 2 w	ent into	
1	, notes, there have be	een historic concerns about 🔠		an explosive behavior and so	ought to	
	ine qualifications and	d training of the 1-1 staff "		attack a surveyor in the ho	me, an	•
i	i At the time of the sui	ITVEV, the facility failed to	' 	emergency situation erupte	d. The	!
	provide evidence that	at staff were effectively	-	staff assigned to chent # 1 tu	arned to	i
:	trained in the implem	nentation of Client #1's RSP	ļ	provide assistance in an eme	ergency	1
- 1	and railed to provide	evidence that staff were	1	situation to prevent a survey	or from	
1	trained in the use of :	special	:	being hit. It was mere reflex	s action	
; ·	techniques/interventi	ions to manage the client's	į.	on the part of the staff w	zith the	
	inappropriate behavio	or,	1	motive of ensuring safety	of a	1
i,	II The facility failed	A		surveyor. As result, staff # 2 a	ssigned	:
,	II. The facility failed to	o ensure starr were		to client # I could not imme	ediately	1
. 1	for cloth sucking was	ensure Client #1's protocol		supervise client # 1 cloth c	howing	•
-	OF CIOUS SUCKING WAS	implemented.	į.	behavior momentarily. However	the	•
! (Cross Refer to W14	0.00 05		staff person will under add	/U, UIU . Jitianal	i
14	#1 on May 1 2008 by	9, 2) Observation of Client etween at 4:44 PM and 5:43	•			
F	PM revealed the clier	nt had a piece of cloth (cloth	;	response in the home.	ituation	
v	was approximate)v 1°	" to 1 1/2" in width and 6" in	i	response in the nome.		
. 1	enoth) that he placed	d in his mouth, on articles of				
f	iurniture on the kitch	en counter, and on the floor.			,	
; ! *	It should be noted that	at at the time of the			!	
g	aforementioned obse	ervations, the staff member				
. 2	assigned to work with	Clients #1, #3, and #6 was			;	
! a	assisting the QMRP a	and another staff member			:	
W	vith a behavioral epis	sode involving Client #2.	į			
					İ	
! H	Review of Client #1's	record on May 2, 2008 at			:	
, a	pproximately 7:40 Pr	M revealed the client had a	į			
3	Standard Procedure	" dated April 10, 2007 that	:			
a	ddressed the client's	s clothe chewing. According				
tc	the section entitled	"Sucking," Client #1 was to	;			
! b/	e supplied cloth piec	ces to chew on that were "at	İ		!	
ile	east 6" X 6" so that st	taff could pull them out of	į :	•		
יח וְ	.is mouth if he starts t	to choke or resists giving	į		•	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY		
		DEMINICATION NOMBER.	A. BUILDING		COMPL	ETED		
	•	09G161	B. WING		05/	12/2000		
NAME OF F	PROVIDER OR SUPPLIER		37-	ET ADDRESS, CITY, STATE, ZIP CO 65 FIRST STREET, SE ASHINGTON, DC 20020		02/2008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX. TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
W 189	Continued From pa	ge 30	W 189	···		-		
	one up." The plant he has chewed on a while, it should be the should be offered a the old one and get verbally praise him. exchanges the old cone, staff should also that is consistent wis survey, the facility fa available/trained to #1 making certain he conducted in a safe 483.430(e)(3) STAF	urther documented that, "once a clean cloth square for a crown away and [Client #1] new one. When he gives up a new one, staff should	W 193	W 193 In answer to W 193, the hereby cross references adopts the facility's answer.	and .			
	Surveyor: 16663 Based on observation of record, the facility able to demonstrate necessary to administrate.	ons, interview and the review failed to ensure staff were the skills and techniques ster interventions to manage ors, for two of the three clients	; ;	W 189.				
	The finding includes	i.	i					
	was able to demons	to ensure Client #2's 1:1 staff trate skills necessary to d behaviors. (See W189, I)						
W 249	effectively trained to chewing protocol. (to ensure staff were implement Client #1's cloth See W189, II) GRAM IMPLEMENTATION	W 249			:		

PRINTED: 05/27/2008

STATEME	ENT OF DEFICIENCIES	E & MEDICAID SERVICES			FQI	RMAPPROVE
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE CONSTRUCTION	CIVIB I	10, 0938-039 E SURVEY
		TOWN TOWN BER.	1	JILDING	COM	PLETED
		09G161	B. WI	NG		
NAME OF	PROVIDER OR SUPPLIER				05	5/02/2008
CHRYS	ALLIS			STRRET ADDRESS, CITY, STATE, ZIP CO 3765 FIRST STREET, SE	DDE	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20020		
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG) 호텔스(III A DE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 31	W 2	249		
				W 249		:
	formulated a aliant	disciplinary team has		1		i ;
	each client must red	individual program plan, eive a continuous active		1. All the program goal	le listad in	1
	treatment program	Consisting of pooded		W 249 except two are o	nacina DT	,
	interventions and se	rvices in sufficient number		programs that were		06-02-08
	; and irequency to su	pport the achievement of the		implemented at time		
	oplectives identified	in the individual program		survey.	or the	
!	plan.	,				'
i		:		2. The QMRP, who w	rae maina	1
i i		i		through post surgery d	ifficultia-	!
:	This STANDARD is	not met as evidenced by:		during the period, was a	his to "	
i	Surveyor; 17620			the programs together	ole to put	İ
!	Based on interview a	nd record review, the facility		after the survey. The proj	ine day	06-03-08
1	raneo to ensure each	Client received continuous		being implemented	grams are	00-03-08
!	interventions, for one	ices, including needed of the three clients (Client				
	#1) included in the s	ample.		3. The QMRP has been i		
i		i		to ensure that		(
}	The finding includes:			implementation is not	program	
÷	Povlovu of Olimus Has			after an ISP no matter	delayed	•
•	7:11 PM revealed the	records on May 2, 2008 at client had an Individual		circumstances may be	wnat the	
	Support Plan (ISP) da	ated April 17, 2007		on sumstances may be.		}
1	Interview with the Qua	Bliffed Mental Retardation		The CEO will monitor t		
! !	Professional (QMRP)	on May 2, 2008 and further		that QMRP implements	o ensure	· .
1	review of Client #1's I	SP revealed program		goals no matter what his	new ISP	
; (objectives including the	ne following were		goals no matter what his	personai	On-going
: 1	ecommended for upo	coming year (2007):		situation may be and eve involve making te		, on going
i -	Given physical assis	tance, [Client #1] will			mporary	
i F	produce the manual s	igns for "please, eat, and		alternative arrangements.		
. 0	rink" for 5 of 5 trials :	as measured by program				,
	locumentation.					!
:	Given physical assis	tanco (Client #41 will		•		
: . <u>p</u>	erticipate in a tableto	p activity on 3 out of 4 trials		i		ļ
, a	week as recorded po	er month for three				

consecutive months.

months by October 2008.

ambulate for 20 minutes, 3 days per week for 12

- One time per week, Client #1 will choose his clothing (given two options) that he will wear for the day with verbal assistance for six consecutive

06/12/	/ <u>2028 20:54 3</u>	018536756	CHR	२४इ	SALLIS INC	PAG	E 35
UEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 05/27/2008
CEIVI	<u>ERS FOR MEDICAR</u> E	& MEDICAID SERVICES			' '	FOR	ベタ インセカ しくにひ
O TWY CIME	INT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) I	N#E JI	LTIPLE CONSTRUCTION	OWR V	<u>10. 0938</u> -0391
-110 F ()()	N OF CORRECTION	IDENTIFICATION NUMBER:				TAG (EX)	E SURVEY
			A. BU	JILĐ	DING	COM	PLETED
		09G161	B. WI	INĠ			†
NAME OF	PROVIDER OR SUPPLIER			$\overline{}$		05	6/02/2008
CHRYS	ALLIS			s	TREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE		
		-			WASHINGTON, DC 20020		
(X4) iD PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECT	TION	
TAG	REGOLATORY DR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	NIII D DE	COMPLETION DATE
W 249	Continued From page	ge 33	W 2	246	n i	-,	
	At the time of the su	rvey, the facility failed to	VV Z	448	9.		İ
	ensure Client #1's n	ew program objectives were 🕒			I		
	implemented timely	as required.			1		1
W 322	483.460(a)(3) PHÝS	ICIAN SERVICES	W 3	322	> !		. 1
	1	!			W 322		i !
	The facility must pro	vide or obtain preventive and				•	·
	general medical care) .			In answer to W. 200 41. C	***.	!
	<u>:</u>				In answer to W 322, the fac	ality	
	!	1			says as follows:		1
	This STANDADD :-						1
	Surveyor: 16663	not met as evidenced by:			1. The stool test could not I		
		nd record review, the facility			immediately completed bec	ause	:
	failed to ensure gene	ral and preventative care			client # 1 toilets independen	atlv	:
	services, for two of the	ne three clients (Clients #1			and flushes the toilet after t	ise He	·
!	and #2) included in t	he sample			also does not make bowel	,DO. IIO	1
	, , , , , , , , , , , , , , , , , , , ,				movement frequently. All e	66-4-	
I	The findings include:	·			by staff to and the start C	HOUS	
:	• • • • • • • • • • • • • • • • • • • •				by staff to get the stool for	he test	
	1. The facility failed t	o ensure Client #1 received			failed. The physician was/i	\$	
	stool test as directed	by the clieπt's Primary Care			aware of attempts and failur	es.	
	Physician (PCP),						
	Later 1 min m			,	2. The nurse has been re-tra	ined to	-
		ility's Qualified Mental			ensure prompt processing o	f	06-04-08
-	Retardation Profession	onal (QMRP) and review of			prescription orders and		, , , ,
	investigative sensets	reports and corresponding			medication delivery in a tim	elv	
	2:11 DM revealed an	on May 1, 2008, beginning at incident involving Client #1			manner. If there are concer		
!		2007. According to the			regarding the orders of outs		;
:	incident report, Client						•
		to some vomiting and			physicians, as in this case th	ere	·
		The client was evaluated		;	was, then the primary care		İ
;		cute gastroenteritis. Client			physician will review the or		:
!	#1 was released on J	апиагу 1, 2008.		,	and determine whether to pr	oceed	
!	.				or treat alternatively.		•
		medical records on May 2,		: !			
		y 2:06 PM revealed a PCP		ļ	<u> </u>		
'	note pated January /.	2008. According to the la "stool gualac, ova and		į	; ·		1
	inote, the FCF wantet	ra scool guarac, ova and					1

PAGE 35

timely manner.

timely manner.

the time of the survey, the facility failed to ensure Client #1 received his antibiotic medication in a

The facility failed to ensure Client #1 was provided with his Erythromycin Ointment in a

Review of Client #1's medical record on May 2, 2008 at 2:35 PM revealed the client was seen by

06/12	/2028 20:54 3	018536756	CHRY	SALLIS INC	PAG	SE 37	
DEPA	RTMENT OF HEALTI	HAND HUMAN SERVICES			PRINT	ED: 05/27/20	ın:
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			rur	(MAPPPA)	<u>~ r</u>
STATEME	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) ML	ILTIPLE CONSTRUCTION	OMBIN	O 0938-03	9
	TOT CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		COMP	SURVEY	
			i				
NAME OF	DDA ADER OD GUILL	09G161	B. WING		0.5	/02/2008	
IAVINE OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		70×72008	_
CHRYS	SALLIS -			3765 FIRST STREET, SE WASHINGTON, DC 20020			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u></u>				
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DUI D BE	COMPLETION DATE	1
W 322	Continued From page	ge 35	W 32	2	-		-
	an Ophthalmologist	on January 17, 2008.	*** 02	#* :		!	
	 According to the cor 	rsultation sheet, the client		3. The nurses have been re-	trained	'	
	→ was prescribed Eryt	hromycin Ointment to bis '		to ensure prompt processing			ı
	Registered Nusse at	terview with the facility's				06-15-08	
	January 2008 Physic	nd review of Client #1's cian's Orders (POS) revealed		manner. This includes in	timely		-
	the client's first dose	of Erythromycin Ointment		and discontinuation of meds		1	-
	, was received on Jan	iuary 31, 2008 (fourteen days 🗸		i and discontinuation of meds	5.	i	1
	i arter it was prescribe	ed). At the time of the survey		1		i	1
	the facility failed to e	nsure Client #1 received his					
W 331	. A83 A60(a) NU IDONA	omycin in a timely manner.				1	1
VV 331	483.460(c) NURSIN	3 SERVICES	W 33	1!		!	ı
	The facility must prov	vide clients with nursing				į	1
	services in accordan	ce with their needs.		:		1	l
	· !	·		,			l
	This STANDADD in	not mot on avid-u				•	ı
	Surveyor: 17620	not met as evidenced by:					
•		n, interview, and record		·			l
ì	review, the facility's n	ursing services failed to		:			ĺ
	ensure that each clie	nt received nursing services		•			
;	in accordance with the	eir needs, for four of the six				:	
	resided in the facility.	2, and #5 and #6) that					١
:	realization and recoming.	·				!	l
; 1	The finding includes:			!			
!	1. The facility failed	to ensure Client #1 was					
	provided with sunscre	een as recommended.				1	
İ		:				•	
		2, 2008 at 5:50 PM revealed				i	
ĺ	Client #1 left the facili						
}	observed to receive	dinner. The client was not iny topical creams before		Γ			ĺ
i	leaving for the evening					!	
!	_	Ť		:		1	
		medical records on May 2,		1			
!	2008 at 12:15 PM rev	ealed the client's. April 2008 🦠		1		i	

PM and concluding at 5:51 PM revealed each client received medications from the residential nurse. After the medications were administered, the corresponding Medication Administration Records (MARs) for each client was reviewed and revealed that three clients had treatment orders that were signed off as given by the nurse. Observation during the medication administration

revealed that the following treatments

/medications were not given as evidenced below:

06/12/1	2028 20:54 3I	018536756	CHR\	/SALLIS INC	PAG	E 39	
CENTE	SES EOD MEDIOVE	HAND HUMAN SERVICES			PRINT	ED: 05/27/2	റവള
STATEMEN	NT OF DEFICIENCIES	& MEDICAID SERVICES			FU	スミストゥラン	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CONSTRUCTION	ONB L	<u>vo. 0938-0:</u>	191
		IDENTIFICATION NUMBER:	A. BUIL		(X3) DAT	E SURVEY	
•			1		001	r Lu i e D	
NAME OF I	PROVIDER OR SUPPLIER	09G161	B. WIN	G		* 10 m -	
	•			STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/02/2008	_
CHRYSA	ALLIS			3765 FIRST STREET, SE			- 1
		<u> </u>	- 1	WASHINGTON, DC 20020			
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES	ID.				- 1
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		OULDE	(XS)	\neg
	·		TĄĠ	CRUSS-KEFERENCED TO THE APP	PROPRIATE	DATE	"
W 331	Continued From pag	19.37		DEFICIENCY)		<u> </u>	
		; ;	W 33	31 <u>;</u>			7
;	a. Client #1 was pre	scribed Hydrophor ointment		!	•	1	
:	TO THE CHINS BUILD ROS	PVPO/ AVADIDA SER OS DAA				•	
	AURITIOSOPIC 0.1% OF	IDIMENT The cintmonto were !		1		!	
•	Signed on as divel b	V IDE DUISE but not abcorded		!		[
	during the medication	n administration.		:	٠	1	-
:						i	-
1	o. Chefit #2 was pres	scribed Ketoconazole 2%				i	
, 1	Ourse but not observe	vas signed off as given by the ed during the medication		:		į	
	administration.	ed during the medication		:			
		:					1
C	Client #5 was pres	cribed Nizorol 2% cream		!		1	
į L	wice day (once at 7:0	00 PM) and Lacintion 12%					
1 19	onon (to be given at 6	$3:00$ PM). The tonicals were \ldots				·	
2	signed off as given by	' the nurse but not observed in				•	
	during the medication	administration.				1	
Ĺ	At the time of the suc	ey, the facility failed to		,		!	
įr	riplement a system th	nat ensured oursing					
p	ersonnel administere	ed and/or monitored the		W331			
а	idministration of the c	lient's topical medications.		. *************************************			
				2 All 45 1			1
, 3	The facility's nursin	ig services failed to ensure		3. All the medication nurse			
a	n enective system that	at documented		facility have received	new		
in	iscontinued medication	ons/treatments was		instructions and retraining	ng on	06-16-08	•
!	iipioriichtea.	į.		medication administration p		00-10-08	
10	bservation of the me	dication administration on		The nurse has been instru		I	1
. A	pril 30, 2008 at 5:33	PM revealed the client was		review all physician orde		1	
) ac	dministered his medic	cation		proper signature and dating		i	
∵ (⊂	Carbidopa/Levodopa)	. Review of Client #1's		MD must sign and date	every		İ
A	pril 2008 Physician's	Orders (POS) on May 2,		notation that the MD makes	on the		[
	008 at 12:15 PM reve			physician orders and i			
E!	ryunromycin Ophth 5r	ng/gm ointment to be		medical records. The DO			
; = F	oplied to each eye ev rythromycin was not o	cry evening. The observed to be		monitor to ensure that the			<i>:</i>
ac	ministered during the	e evening observation		strictly comply with the fa			,
		nued review of the POS		medication administration p			
				, and the second second p	oney.		

PRINTED: 05/27/2008 FORMAPPROVED

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO	<u>) 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	·	09G161	B. WI	NG.		OF	Π Δ (Δ
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		TOCCT ADDRESS AND TO TO	1 03/	02/2008
CHRVe			,	131	REET ADDRESS, CITY, STATE, ZIP CODE		
CHRYS	ALLIS				3765 FIRST STREET, SE	•	
/V4) ID	CUMPAN DV OT			<u> </u>	WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBF	(X5) COMPLETION DATE
W 331	Continued From pa	age 38	w:	331			-
		written notation "D/C'd" was	•••	00 1	1		1
	documented adjac	ent to the Erythromycin order.			;		•
	It should be noted	that notation failed to be			İ		t
	initialed or dated by	the person that made the					•
	notation. Additiona	illy, the printed POS had an					1
	area designed on t	he form for the documentation			i		
;	of discontinued me	dications. The area made			!		
İ	provision for date, t	ime, and person initials to be			I .		
ļ	documented.	, , , , , , , , , , , , , , , , , , , ,					
:	*	}					
	Interview was cond	ucted with the facility's					
i	Registered Nurse (I	RN) on May 2, 2008, to					
:	ascertain information	on about the Client #1's] 		
	Erythromycin, Acco	ording to the RN, the			•		
:	medication was dis-	continued on March 27, 2008,			•		
	the date Client #1's	April 2008 POS was signed			· :		
į	by the physician. R	eview of Client #1's					
j	Medication Adminis	tration Record on May 2,			:		•
•	2008, however, rev	ealed the Erythromycin was			!		:
	administered until N	farch 30, 2008. At the time of					ì
;	the survey, the actu	al discontinuation date for					
i	Client #1's Erythron	nycin could not be determined.					•
i	مار عالك المالات المالات المالات المالات المالات المالات المالات المالات المالات المالات المالات المالات المال	nina managural felle dis					
		sing personnel failed to were administered at the			W331		ŀ
		accordance with their			W 331		
į	"Medication Adminis	stration" policy					
i	Wedication Admini	stration policy.			4. All the medication nurses	in the	
1	Observation on the	evening modication			facility have received new		
		evening medication			instructions and retraining o	un.	•
		pril 30, 2008 beginning at 5:10 in at 5:51 PM revealed each					06-16-08
		ications. Review of the			medication administration p		
		cations. Review of the cards			The DON will monitor to en	-	ľ
	(MARs) for each clie				that the nurses strictly comp	ly	, [
		ration revealed clients were			with the facility's medication	ıπ	1
		e medications at different			administration policy/sched		İ
	times, for example:	thousalions at different				maw.	,
į'	antos, for example.	·					, i
	Client #1 was sched	luled to receive his			•		

FAGE	41
•	
MITER.	

DEPA	RTMENT OF HEALT	AND HUMAN SERVICES	911	NONCETO INC	4	4GE 41	
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			PRINT	ED: 05/27/2	800
	NI CE HEEK ENCIEC	(X1) PROMPERIOR			OMB	RMAPPROV	/ED
ANDPLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE CONSTRUCTION	OMB NO. 0938-0		<u> 197</u>
			A. 60	ILDING	COM	APLET ED	
		000404	B, WI	NG.			
NAME OF	PROVIDER OR SUPPLIER	09G161				5/02/22	- 1
			-	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	5/02/2008	
CHRYS	ALLIS			3765 FIRST STREET, SE	<u> </u>		- 1
 _				WASHINGTON, DC 20020			
(X4) ID PREFIX	: SUMMARY STATE	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR			
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL CONTROL OF THE PRECEDED BY FULL CONTROL OF THE PRECEDENCIES	ID PREFI	IN ! (EACH CORRECTIVE ACTION &	U⇔ur n ne	(X5) COMPLETIO	
<u> </u>	<u> </u>	E I I I I I I I I I I I I I I I I I I I	TAG	CRUSS-REFERENCED TO THE AP	PROPRIATE	DATE	N
W 331	Continued From pag	20		DEFICIENCY)		;	
	, pay	je 39	W 3	331 <mark> </mark>			7
	administered bi-	at 7:00 PM. The client was		<u>!</u>		ł	
	administered his me	dication at 5;33 PM.		ļ			
	: Client #5 was school	ulad ta analysis is a second		i		i	- 1
	Naltrexone Hydrochi	uled to receive his Haldol and oride at 7:00 PM. The client		'			
	received his medicat	ions at 5:22 DM		į			
!		19119 At 0.25 P W.					-
į	Client #6 received his	s medications including				}	
:	Annoxicilin and Simv	astatin at 5.18 PM The				!	
i	Amoxicillin was sche	duled to be administered at 1		5 The Older		:	
•	7:00 PM. The Simva	Statin was scheduled to be		5. The QMRP and client #	: 3 day	:	1
}	administered at bedti	me.		program had a meeting to	ensure		
	Review of the facility	- 116.6		that the day program admi	nisters	04-28-08	
	Review of the facility's	s Medication		medication in compliance	with	0 + 20-00	
1	that "medications ma	on May 2, 2008 revealed y be administered within a		physician orders. The DO	N and		
:	Window of one hour n	rior to and up to one hour		the QMRP will more aggre	zeivelv		
:	after the prescribed to	me." At the time of the		monitor medication adminis	tention	i	
:	survey, the facility fail	ed to ensure the		in the day programs to ensu	114UON	00.00	ĺ
()	mplementation of its	"Medication Administration"				06-16-08	
	policy making certain	that medications were		complied with.	strictly	!	
4	administered at the so	heduled time.		complicit with.		1	
i	The second of the second	j		i			
	o. The facility failed to	ensure that Client #3's day		:			
Į,	vith his physician	medications in compliance		6 The Don't I	4		
V	vith his physician's or	ders. (See W368)		6. The DON has instruct			
l e	The facility's aurein	# man = = = 1 E= 11		nurse to clearly indicate wh	en she	06-16-08	
ء ا	 The facility's nursing orders 	g personnel falled to were correctly documented		receives telephone orders fro	om the	!	
; e	and signed by the phy	sician timely		physician and sign and da	te the		
	and pily	Side of the first of the second of the secon		order as provided. The nu	rse as		
į (·	Cross Refer to W368	, 1] Review of the medical		also been instructed to ensi	ure all		ĺ
Г	ecords at Client #3's d	day program on May 1.		physician telephone order		On-going	4
2	008, revealed a phys	cian's order dated July		subsequently signed off b		i 6 6	7
2	007 that documented	the client should receive			•		
Δ	urodex drops to both	ears twice daily (one of the		physician. The DON will m		•	İ
¹ þ	rescribed doses was	to be administered at the		the administrative nurse to			l
d	ay program). Review	of Client #3's medical		compliance with these proce	dures.		i

records at the residential facility on May 2, 2008

PAGE 42

CEMI	RS FOR MEDICARI	H AND HUMAN SERVICES				FUK	D: 05/27/20 MAPPROVE
つ・マ・ビバビ	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		09G161	B. WIN	NG_			
NAME OF	PROVIDER OR SUPPLIER			_		05/	02/2008
CHRYS,	ALLIS			3	REET ADDRESS, CITY, STATE, ZIP CODE 765 FIRST STREET, SE		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D. D.C.	(X5) COMPLETION DATE
W 331	Continued From page	ge 40	14/ 2	24			
V 368 14	however, revealed a March 31, 2008 that aforementioned Aur review of the interim signed by the facility but not signed/review physician. Additional by the nurse failed to received (i.e. telephotothat review of the Aurodiscontinued on Marcsurvey, the facility failed the nursing personner physician's orders and eviewed by the primare 183.460(k)(1) DRUG	in written interim order dated discontinued the odex ear drops. Continued order revealed the order was stated by the primary care lly, the interim order written ordentify how the order was one order). It should be noted ril 2008 Physician's Orders odex drops were och 3, 2008. At the time of the led to provide evidence that of accurately documented discourately documented discourately documented discourately documented and ensured the orders were any care physician.	W 36				
ι	nat all drugs are adm ne physician's orders	illistered in compliance with		:			
B fe	urveyor: 16663 ased on interview ar illed to ensure that n dministered in comp	liance with the physician's hree clients (Clients #1 and		:	W 368		
	he findings include:	npie.			In response to W 368, the facili says as follows:	ty	
וק,	The facility failed to ogram administered the his physician's order.	ensure that Client #3's day , medications in compliance ders.			1. The QMRP and client #3 program had a meeting to ensthat the day program administ	ште	04-28-08

Interview with the day program's nurse on May 1, 2008 at 11:25 AM revealed Client #3 received ear

physician orders.

medication in compliance with

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STATEMEN	T OF DEFICIENCIES	(V1) PEO(MOTE IN INC.				<u> </u>	<u>10. 0938-039</u>
ANDPLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G161	B. WI	NG_			· · · · · · · · · · · · · · · · · · ·
CHRYSA	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 1765 FIRST STREET, SE	05	/02/2008
(X4) (D	CI IMMA DV DTA			<u> </u>	VASHINGTON, DC 20020		
PREFIX TAG	REGULATORY OR LS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	.,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HILD RE	(X5) COMPLETION CATE
W 368	Continued From pag		w:	368			:
W 426 V 66 T SE	drops as needed (Plapaín. Review of the medic program on May 1, 2 order dated July 200 should receive Aurordaily (one of the presadministered at the collient #3's day progradministration Recoil however, failed to prowas receiving the medical macrosoft and the collient received the easordered. At the time failed to ensure Client in accordance with his 2. The facility failed to Erythromycin was adwith the physician's of 483.470(d)(3) CLIEN. The facility must, in a clients who have not be water temperature and ensure that the temperature	cal records at Client #3's day 2008, revealed a physician's 77 that documented the client idex drops to both ears twice scribed doses was to be day program). Review of the ram Medication ords (MAR) on May 1, 2008 rovide evidence that the client edication as prescribed. The s of July 2007 through if to provide evidence that the ar drops on a daily basis as softhe survey the facility int #3 received his ear drops is physician's order. Ito ensure Client #1's iministered in accordance orders. (See W331, 3) IT BATHROOMS areas of the facility where been trained to regulate re exposed to hot water, erature of the water does not Fahrenheit. In and interview, the facility the temperature of the water egrees Fahrenheit.	W 42		2. The DON and QMRP more aggressively monitoresidential nurse and the program nurse to ensure a consistent administration of in compliance with physorders.	r the day more drugs	06-16-08 On-going

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G161	B. WING			05/02/2008	
NAME OF	PROVIDER OR SUPPLIER ALLIS		37	EET ADDRESS, CITY, STATE, ZIP (65 FIRST STREET, SE ASHINGTON, DC 20020		12/2008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
	2008, the hot water fluctuate between 1 were interviewed to the client's access the client's access the client's access the water temperature did not 483.470(g)(2) SPACT The facility must furnand teach clients to choices about the use hearing and other coand other devices id	in the facility was noted to 15 and 120 degrees. Staff ascertain information about to the hot water during bath ed that the clients required withing and required staff to rature. At the time of the tiled to ensure the hot water exceed 110 degrees. EE AND EQUIPMENT wish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids, braces,	W 426	l. At the time of the water temperature we degrees Fahrenheit was tested with thermometer. The was further regulated down the thermostat heater. The QMRP will temperature checks ensure that the temperature does not degrees.	as about 112 when water a new temperature d by turning on the water monitor the logs and hot water		
	Surveyor: 17620 Based on observation failed to ensure necessary maintained in graph three clients (Clients) The finding includes Observation and interpretation of the environmental with the environmental with the environmental with the environmental with the environmental with the environmental with the environmental with the environmental with the environmental with the environmental environmental with the spoon was observed. Interview with the spoon was observed.	not met as evidenced by: In and interview, the facility essary adaptive equipment bod repair, for one of the #1) included in the sample. Professional (QMRP) during alkthrough on May 2, 2008, mately 2:57 PM revealed we feeding equipment andled spoon. The handle of red to be melted and was conducted with the certain if replacement					

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T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE SURVEY COMPLETED	
		1	G			
	09G161	B. WING _		05/	02/2008	
		37	765 FIRST STREET, SE	Ē		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION \$	HOULD BE	(X5) COMPLETION DATE	
utensils were on sit usage. The QMRF available and proced drawers to present of survey, however, evidence of the repfailed to maintain C	e and available for Client #1's revealed that utensils were seded to search the kitchen them to surveyor. At the time the QMRP failed to provide facement utensils. The facility lient #1's built-up handled	W 436	answers as follows: 1. Client # 1 built-up spoo	n was good	06-16-08	
483.470(l)(1) INFECT There must be an a prevention, control,	ctive program for the and investigation of infection	W 455	The spoon has been rep QMRP shall monitor the maintenance of utensils of	laced. The service and f client # 1	On-going	
Surveyor: 17620 Based on observatir that procedures for disease were impleiglients (Client #1) in The finding includes (Cross Refer to 149 on May 1, 2008 between the client happroximately 1" to length) that he place furniture, on the kitter Staff were not observed them. At the time of to provide evidence	on, the facility failed to ensure prevention of communicable mented for one of the three cluded in the sample. 3. 3. 3. 3. 4.2) Observation of Client #1 ween at 4:44 PM and 5:43 PM and a piece of cloth (cloth was 1 1/2" in width and 6" in ed in his mouth, on articles of then counter, and on the floor reved to clean the furniture, er the cloth was placed on the survey, the facility failed that procedures to prevent		client #1 is unsavory and p at some risk for acquiring a hence, the BMP. The sta assigned to assist client temporarily unavailable to the referenced time perio behaviors due to the behavi- of another person who additional staff assistance. the staff shall implement	laces him in illness; iff person #1 was witness d of the oral crisis required However, ient the	06-16-08	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa utensils were on sit usage. The QMRP available and proce drawers to present of survey, however, evidence of the rep failed to maintain C spoon in good repa 483.470(I)(1) INFEC There must be an a prevention, control, and communicable This STANDARD is Surveyor: 17620 Based on observative that procedures for disease were imples clients (Client #1) in The finding includes (Cross Refer to 149 on May 1, 2008 bets revealed the client h approximately 1" to length) that he place furniture, on the kito staff were not losser communicable disease communicable disease communicable disease communicable disease	OPENTIFICATION NUMBER: OPENVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 utensils were on site and available for Client #1's usage. The QMRP revealed that utensils were available and proceeded to search the kitchen drawers to present them to surveyor. At the time of survey, however, the QMRP failed to provide evidence of the replacement utensils. The facility failed to maintain Client #1's built-up handled spoon in good repair. 483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, the facility failed to ensure that procedures for prevention of communicable disease were implemented for one of the three clients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures to prevent communicable disease were adequately	DENTIFICATION NUMBER: 09G161 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Utensils were on site and available for Client #1's usage. The QMRP revealed that utensils were available and proceeded to search the kitchen drawers to present them to surveyor. At the time of survey, however, the QMRP failed to provide evidence of the replacement utensils. The facility failed to maintain Client #1's built-up handled spoon in good repair. 483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Surveyor: 17620 Based on observation, the facility failed to ensure that procedures for prevention of communicable disease were implemented for one of the three clients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures to prevent communicable disease were adequately	PROVIDER OR SUPPLIER ALLIS SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Utensils were on site and available for Client #1's usage. The QMRP revealed that utensils were available and proceeded to search the kitchen drawers to present them to surveyor. At the time of survey, however, the QMRP falled to provide evidence of the replacement utensils. The facility failed to maintain Client #1's built-up handled spoon in good repair. 483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Surveyor, 17620 Based on observation, the facility failed to ensure that procedures for prevention of communicable diseases were implemented for one of the three clients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor. Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures to prevent communicable disease were adequately The finding includes: A BUILLING STREET ADDRESS, CITY, STATE ZIP COD 3768 FIRST STREET, SE WASHINGTON, DC 20020 PREPRIX TAG PREPRIX TAG FROMING PROPRICE ACTIONS W 436 Utanie The CMMP Find the time of the survey of the time answers as follows: 1. Client #1 built-up spoon until few days to the survey and pate on the facility failed to ensure that procedures to prevent continued to provide evidence that procedures to prevent continued to provide evidence that procedures to prevent continued to provide evidence that procedures to prevent continu	Denoting the prevention of the survey. The spoon has been replaced. The gravention, control, and investigation of infection and communicable disease were implemented for one of the the edients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM everyed the client had a piece of ooth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in the mount, on the kitchen contrains of the survey, the facility failed to reprovide the provide that procedures for prevention counter, and on the floor Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures for prevention of communicable discases were implemented or one of the three clients (Client #1) included in the sample. The finding includes: (Cross Refer to 149, 2) Observation of Client #1 on May 1, 2008 between at 4:44 PM and 5:43 PM evealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of furniture, on the kitchen counter, and on the floor Staff were not observed to clean the furniture, counter, or floor after the cloth was placed on them. At the time of the survey, the facility failed to provide evidence that procedures to prevent communicable disease were adequately	

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/02/2008 09G161 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3765 FIRST STREET, SE **CHRYSALLIS** WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1000 1000 INITIAL COMMENTS Surveyor: 17620 A relicensure survey was conducted from April 30, 2008 through May 2, 2008. A random sample of three residents was selected from a residential population of six males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports. 1082 3503.10 BEDROOMS AND BATHROOMS 1082 Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting This Statute is not met as evidenced by: Surveyor: 17620 Based on observation and interview, the facility failed to ensure all bathrooms were equipped with 1082 toilet paper holders, cups and cup dispensers, for three of the six residents (Residents #2, #4 and As answer to 1082, the facility #5) that resided in the facility. says as follows: 1. The bathrooms used by clients The finding includes: 5/15/8 # 2, # 4, #5 and indeed all the ongoing 1. During the environmental inspection on May 2, residents are now fully equipped 2008 beginning at 2:57 PM revealed Residents with toilet paper holders, cups #2 ,#4 and #5's bathrooms failed to have cup and cup dispensers dispensers and/or cups. Additionally, toilet paper was observed to be housed on the back of the 2. The hole in the wall in the 5/15/8 toilet in Residents #4 and #5's bathroom (no toilet referenced bathroom has been paper holder). Interview with the facility's House repaired. Manager on May 2, 2008 revealed that the aforementioned needed items would be obtained. Health Regulation Administration

STATE FORM

06-11-2008

(X6) DATE

TITLE

							<u>-</u>		
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N			(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G161		B. WING		05/0	2/2008		
NAME OF P	ROVIDER OR SUPPLIER	. <u>. </u>	STREET ADI	DDRESS, CITY, STATE, ZIP CODE					
CHRYSA	LLIS			ST STREET, S STON, DC 20					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE			
I 082	Continued From pa	age 1		1 082					
	2. The bathroom located on the left side of the house, closes to the dining room was observed to have a large hole on the wall behind the door.								
. 1 090	1 090 3504.1 HOUSEKEEPING		1 090						
	The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.								
	Surveyor: 17620 Based on observated failed to ensure the	met as evidenced by tion and interview, the e interior of the facility fe, clean, orderly, attr	e GHMRP / was						
 - 	The findings includ	le:		:					
	Mental Retardation Manager during the	nterview with the Quant Professional and/or environmental walk vealed the following:	House						
	Hallway								
; ; ;	bedrooms was obs	est to Residents #2 a served to have an are por where the weathe r not secured.	ea at the	1					
	Bedrooms								
	1. Resident #5's la	amp was inoperable ((no bulb).						
[]]	2. Resident #5's b	rown comforter was	observed	1		4			

to be stained. There were dark stains present

			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	09G161		B. WING		05/02/2008	
PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
ALLIS						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOT	OULD BE COMPLETE	
and white marks too comforter that cove Additionally, Reside observed to be stair. 3. Resident #5's pil tear was observed it. 4. Resident #4's whitears located at the covering closest to to to the stair. 5. Residents #3, #4 observed to be housno covers protecting Residents #1, #3, #4 observed to have opmaintained in the caloriginally housed the caloriginally housed the feet of the stair for the carpet leading #6's bedroom was to hazard. Living Room/TV Rocal The ceiling dome House Manger/Quality Professional's office. 7. The track lighting noperable.	wards the top end of red the resident's pill nt #6's comforter waned with some white lowcase was worn an its seam. In its bed covering had top/upper edge of the head of the bed. In and #5's toothbrush sed in their hygiene key them. Additionally, and #5's hygiene key them bars of soap that reboard container the soap. It white bottle observate kit that failed to be dent #2's bedroom very to the entrance of lower posing a potential or mosing a potential was inoperable. In the television roo	low. Is marks. Ind a large diseveral eles were eles were eled in ele labeled. It was Resident al trip election mission		As answer to 1090, the facility responds as follows: The weather stripping near a hallway exit has been repaired. 1. Resident # 5 lamp has a working light bulb. 2. Resident # 5 comforter has been has been cleaned. His tripillow case replaced. 3. Resident # 6 comforter has been cleaned. 4. Resident # 4 turn white be covering has been replaced. 5. Residents #3, #4 and #5 no has new protecting covers. A residents #1, #3, #4 and #5 a soap containers. 6. The white bottle in client is hygiene kits has been labeled accordingly. 7. Radio was removed. 8. The carpet leading to reside # 6 room has been trimmed at the potential hazard removed. Living Room/ TV Room The ceiling dome light, the tracking light and the track a	t the ed. surn surn surn d dso, re in 4 4 lent und	5-15-08
3. A bulb was missing in the row of track lighting				•		; ·
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L: Continued From pa and white marks to comforter that cove Additionally, Reside observed to be stain 3. Resident #5's pil tear was observed i 4. Resident #4's wh tears located at the covering closest to t 5. Residents #3, #4 observed to be hous no covers protecting Residents #1, #3, #4 observed to have op maintained in the ca originally housed the 6. There was a larg Resident #4's hygier 7. The radio in Resi inoperable. 8. The carpet leading #6's bedroom was to hazard. Living Room/TV Roc 1. The ceiling dome House Manger/Quali Professional's office 2. The track lighting noperable.	OP CORRECTION OPG161 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL Continued From page 2 and white marks towards the top end of comforter that covered the resident's pill. Additionally, Resident #6's comforter was observed to be stained with some white 3. Resident #5's pillowcase was worn a tear was observed in its seam. 4. Resident #4's white bed covering had tears located at the top/upper edge of the covering closest to the head of the bed. 5. Residents #3, #4 and #5's toothbrush observed to be housed in their hygiene kno covers protecting them. Additionally, Residents #1, #3, #4 and #5's hygiene kno covers protecting them. Additionally, Residents #1, #3, #4 and #5's hygiene kno covers protecting them. Additionally, Residents #1, #3, #4 and #5's beginner the originally housed the soap. 6. There was a large white bottle observed to have open bars of soap that maintained in the cardboard container the originally housed the soap. 7. The radio in Resident #2's bedroom vn inoperable. 8. The carpet leading to the entrance of #6's bedroom was torn posing a potential hazard. Living Room/TV Room 1. The ceiling dome light located outside House Manger/Qualified Mental Retarda Professional's office was inoperable. 2. The track lighting in the television roon operable.	OPGIGNECTION OPGIGN OPGIGN STREET ADD STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 and white marks towards the top end of the comforter that covered the resident's pillow. Additionally, Resident #6's comforter was observed to be stained with some white marks. 3. Resident #5's pillowcase was worn and a large tear was observed in its seam. 4. Resident #4's white bed covering had several tears located at the top/upper edge of the covering closest to the head of the bed. 5. Residents #3, #4 and #5's toothbrushes were observed to be housed in their hygiene kits with no covers protecting them. Additionally, Residents #1, #3, #4 and #5's hygiene kits were observed to have open bars of soap that were maintained in the cardboard container that originally housed the soap. 6. There was a large white bottle observed in Resident #4's hygiene kit that failed to be labeled. 7. The radio in Resident #2's bedroom was inoperable. 8. The carpet leading to the entrance of Resident #6's bedroom was torn posing a potential trip hazard. Living Room/TV Room 1. The ceiling dome light located outside the House Manger/Qualified Mental Retardation Professional's office was inoperable. 2. The track lighting in the television room was noperable.	OF CORRECTION Description	A BUILDING BURNAY STATEMENT OF DEFICIENCIES SIMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY MUST BE PRECEDED BY DULL (SACH DEFICIENCY) COntinued From page 2 and white marks towards the top end of the comforter that covered the resident's pillow. Additionally, Resident #6's comforter was observed to be stained with some white marks. 3. Resident #5's pillowcase was worn and a large tear was observed in its seam. 4. Resident #4's white bed covering had several tears located at the top/upper edge of the covering closest to the head of the bed. 5. Resident #4's white bed covering had several tears located at the top/upper edge of the covering closest to the head of the bed. 5. Resident #3, #4 and #5's toothbrushes were observed to be housed in their hygiene kits with no covers protecting them. Additionally, Resident #4 turn white be covering has been cleaned. 4. Resident #4 turn white be covering has been replaced. 5. Resident #4 turn white be covering has been replaced. 5. Resident #3, #4 and #5 is has new protecting covers. A name to 1090, the facility responds as follows: The weather stripping near a hallway exit has been replaced. 3. Resident #5 comforter has been has been cleaned. 4. Resident #4 turn white be covering has been replaced. 5. Resident #4 turn white be covering has been replaced. 5. Resident #3, #4 and #5 is has new protecting covers. A name the precent of	OBCOMPLE OBSINGUION OBG161 STREET ADDRESS. CITY, STATE, ZIP CODE AS answer to 1090, the facility responds as follows: The weather stripping near at the hallway exit has been repaired. 1. Resident # 5 conforter has been has been cleaned. His turn pillow case replaced. 3. Resident # 5 conforter has been abeen cleaned. His turn pillow case replaced. 4. Resident # 5 conforter has been cleaned. 4. Resident # 4 turn white bed covering has been replaced. 5. Residents #1, #3, #4 and #5 in yelpene kits were observed to have open bars of soap that were maintained in the cardboard container that onginally housed the soap. 6. There was a large white bottle observed in Resident #4's hygiene kit shaffeld to be labeled. 7. The radio in Resident #2's bedroom was from posing a potential trip hazard. 8. The carpet leading to the entrance of Resident #6 from has been replaced. 9. Residents #1, #3, #4 and #5 are in soap containers. 1. The radio in Resident #2's bedroom was from posing a potential trip hazard. 1. The radio in Resident #2's bedroom was from posing a potential trip hazard. 1. The cal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

09G161

A. BUILDING

B. WING _____

05/02/2008

NAME OF PIROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHRYSALLIS

3765 FIRST STREET, SE WASHINGTON, DC 20020

_	WASHIII	101011, 00 21		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 090	Continued From page 3 in the living room.	1090	1180: [#1.]Please reference the responses cited below. As answer to W 104, the facility	
ĩ 180	3508.1 ADMINISTRATIVE SUPPORT	1 180	hereby cross-references and adopts the answers to W 149 and W 189.	
	Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans.		The Governing Body will ensure that all staff is re-trained with follow up re-training (60-90 days after 1 st session) in concerned areas. Supervising staff will be required to provide job practice monitoring to assess carry-over of information and procedures that reflect current policies of the organization.	6-16-08
	The finding includes: 1. The facility failed to provide continuous active treatment services. [See Federal Deficiency Report Citation W104 and W249]		W 249 1. All the program goals listed in W 249 except two are ongoing PT programs that were being	
	2. The facility failed to ensure that its Qualified Mental Retardation Professional (QMRP) adequately monitored, integrated, and coordinated each resident's active treatment program [See Federal Deficiency Report Citation W159]	n	implemented at time of the survey. 2. The QMRP, who was going through post surgery difficulties during the period, was able to put the programs together the day.	6/10/8
1 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be	I 229	the programs together the day after the survey. The programs are being implemented. 3. The QMRP has been instructed	·
	limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive	9	to ensure that program implementation is not delayed after an ISP no matter what the circumstances may be	4/28/8

FORM APPROVED (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/02/2008 09G161 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3765 FIRST STREET, SE CHRYSALLIS WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1229 1229 Continued From page 4 The CEO will monitor to ensure technologies; that OMRP implements new ISP 4-28-08 goals no matter what his personal This Statute is not met as evidenced by: situation may be and even if will Surveyor: 17620 involve making temporary Based on observation, interview and record review, the GHMRP failed to ensure staff were alternative arrangements. effectively trained on the implementation and documentation of each resident's behavior In response to W 159(1) crosssupport plan, for two of the three residents references and adopts the answers 6-16-08 (Residents #1 and #2) included in the sample. contained in W 120, 149, 189. The finding includes: 249. The facility failed to provide evidence that the direct care staff were able to demonstrate competency in the implementation of each resident's Behavior Support Plan (BSP) and 1229 behavior protocol. (See W189 and W193) As answer to 1229, the facility 1260 3512.1 RECORDKEEPING: GENERAL 1260 says as follows: **PROVISIONS** Consultation with the behavior Each Residence Director shall maintain current and accurate records and reports as required by specialist and psychologist shall this section. be conducted to review revised 7-30-08 training curricula on behavior This Statute is not met as evidenced by: management and individual Surveyor: 17620 Based on interview and record review, the Group BSPs. Revisions shall focus on Home for Mentally Retarded Persons (GHMRP) ensuring competency based failed to maintain each residents' records, for one trainings and reflective of the of the three residents (Resident #2) included in learning needs of new and current the sample. staff members

The finding includes:

evidenced below:

The facility failed to ensure a complete medical assessment was available for review as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		09G161		B. WING _		05/0	<u>2/</u> 2008	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	00/0	2,2008	
CHRYSA	ALLIS			RST STREET, SE NGTON, DC 20020				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
I 260	Continued From pa	ge 5	-	J 260	1260	1260		
l 291	2, 2008, at 12:18 PI assessment dated I review of the reside revealed that it had the Primary Care PI with the facility's Re 2008, revealed that from the assessmenthere was no docum resident's medical re 3514.2 RESIDENT	#2's medical record M revealed a medica November 8, 2007. Int's medical assessmot been signed or drysician (PCP). Integistered Nurse on M some pages were mit. At the time of the mented evidence that ecord was maintaine RECORDS	I Further ment lated by erview ay 2, issing survey, the d.	l 291	As response to 1260, the fa says as follows: 1. Client # 2 medical assess was pulled during other thir party monitoring visits prior the survey, and subsequent incorrectly filed. This error corrected on 5/03/08. The and the QMRP will monito ensure consistent compliance with proper filing procedure.	sment rd or to ly was DON or to ce	5/5/8 ongoing	
	signed by each indiv This Statute is not r Surveyor: 17620 Based on interview a failed to ensure that record was signed a clients (Client #1) in The finding includes Observation of the n April 30, 2008 at 5:3 administered his me	met as evidenced by: and record review, the each entry into a clie and dated, for one of acluded in the sample medication administrations. Review of Client 's Orders (POS) on It evealed an order for almology 5mg/gm oir ye every evening. Covealed the hand write documented adjace It should be noted the signed or dated by the notation. Additions	entry. The facility ent's three ention on lient was ention to ontinued entite the entite to the entite entity.		1. The nurse has been insto review all physician order proper signature and dating MD must sign and date notation that the MD mathe physician orders and medical records. The DO more aggressively monitor in clients' records to consistent compliance recording procedures.	ders for g. The e every kes on in the DN will	6-16-08 On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G161				(X2) MULT A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED	
NAME OF L	PROVIDER OR SUPPLIER	1 096161	STREET ADD	DESS CITY	STATE, ZIP CODE	05/0	2/2008
CHRYSA			3765 FIRS	T STREET, TON, DC 2	, SE		
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l 291	Continued From pa	 ige 6		l 291			
	for the documentati medications. The a time, and person's i the time of the surv	ion of discontinued area made provision initials to be docume rey, the facility failed ton Client #1's April 20	ented. At to ensure		1379 As answer to 1379, the fa	acility	
1 379	3519.10 EMERGEN	NCIES		I 379	says as follows:	1 41	
	In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for two of the six residents (Residents #2 and #6) that resided in the facility. The finding includes:				1. Both the QMRP Incident management co- have received r instructions to notify De of Health of any involving all the client facility by telephone imm and in writing within 24 l The CEO shall monitor to to ensure consistent co- with the aforesaid instruc The facility notifies parer	ordinator mandated epartment incidents s in the mediately hours. this issue mpliance etion.	
					Guardians of serious inc required by the facility's management policy. notifications are done QMRP on telephone. telephone notifications reflected on the incider forms reviewed by the sur However, the facility reviparent /guardian no	idents as incident Usually, by the These are not nt report rveyors. iewed its tification	6/16/08
	Retardation Profess the facility's incident	ncility's Qualified Men sional (QMRP) and re is reports on May 1, 2 M revealed the follow	eview of 2008,		system on 6/04/08 and he all telephone notification be reflected on the file the incident report in the as additional note.	ons must copy of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NI			A. BUILDING	PLE CONSTRUCTION	— COMPLE	(X3) DATE SURVEY COMPLETED 05/02/2008	
NAME OF S	PROVIDER OR SUPPLIER	Dacioi	STREET AD	DRE\$S, CITY. S	TATE, ZIP CODE		
CHRYSA			3765 FIR	ST STREET, GTON, DC 20	SE		
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1379	On April 27, 2008, staff reported that Resident #6 fell and hit his right eye and left hand on the corner of his nightstand. The client was taken to the emergency room for evaluation and treatment. On December 31, 2007, staff reported that Resident #6 was taken to the emergency room due to being unable to walk. The client was treated at the emergency room and diagnosed with fatigue. On October 25, 2007, staff reported that Client #2 fell and hit his mouth which resulted in the resident cracking/breaking his right front tooth. At the time of the survey, the facility failed to ensure the Department of Health notified of the aforementioned incidents as required (both immediately and provided with written notification			1379			
	immediately and provided with written notification within 24 hours). 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnorand evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Surveyor: 17620 Based on interview and record review, the GHMRP failed to ensure general and preventative care services, for two of the three residents (Resident #1) included in the sample		h diagnosis of ment vent by the by: the	1401			

The findings income Health Regulation Administration STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G161		B. WING		05/02	2/2008
	TO MOSE OF CURRIED	096161	STREET ADD	RESS CITY S	STATE, ZIP CODE	00/02	12000
NAME OF F	ROVIDER OR SUPPLIER			T STREET,		~	
CHRYSA	LLIS		WASHING	TON, DC 20	0020	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
l 401	The facility failed to ensure Resident #1			I 401	As response to 1401, the factors as follows:	facility	
	received stool test as directed by the resident's Primary Care Physician (PCP). Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on May 1, 2008, beginning at 2:11 PM revealed an incident involving Resident #1 dated December 31, 2007. According to the incident report, Resident #1 was sent to the emergency room due to some vomiting and prolonged diarrhea. The resident was evaluated and diagnosed with acute gastroenteritis. Resident #1 was released from the emergency room on January 1, 2008. Review of Resident #1's medical records on May 2, 2008 at approximately 2:06 PM revealed a PCP note dated January 7, 2008. According to the note, the PCP wanted a "stool guaiac, ova and parasite test completed. Interview with the facility's Registered Nurse on May 2, 2008, revealed the test was not conducted. At the time of the survey, the facility failed to ensure Resident #1 received the aforementioned required test. 2. The facility failed to ensure Resident #1 received his antibiotic treatment in a timely manner. Review of the facility's incident reports on May 1, 2008 at 2:11 PM revealed an incident involving Resident #1 dated September 12, 2007. According to the report, Resident #1 was taken to the emergency room due to weakness. Review of Resident #1's nursing note dated September 13, 2007 revealed that the resident was diagnosed with bronchitis and was prescribed				1. The stool test could not immediately completed be client # 1 toilets independ and flushes the toilet after also does not make bowel movement frequently. All by staff to get the stool for test failed. The physician aware of attempts and fail	ecause lently r use. He l l efforts or the n was/is	6/4/08
					2. The nurse has been re- to ensure prompt process prescription orders and medication delivery in a t manner. If there are cond regarding the orders of or physicians, as in this case was, then the primary car physician will review the and determine whether to or treat alternatively.	ing of cerns atside there e order	6/4/08 On- going
					·		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G161		B. WING		05/02	/2008
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
CHRYSA	LLIS			T STREET, TON, DC 20			
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I 401	revealed the Reside Care Physician (PC According to the ph 2007), the resident regimen." Review 2007 Medication A however, revealed not begin until Septit was initially preso survey, the facility freceived his antibio manner. 3. The facility failed provided with his E timely manner. Review of Resident	ergency room. If Resident #1's recordent was seen by his local processes by his local proc	Primary 5, 2007. nber 15, evaquin otember d (MAR) aquin) did lays after f the dent #1 mely #1 was at in a	I 401	3. The nurses have trained to ensure	prompt	6-16-08
	 2, 2008 at 2:35 PM revealed the resident was seen by an Ophthalmologist on January 17, 2008. According to the consultation sheet, the resident was prescribed Erythromycin Ointment to his eyes at bedtime. Interview with the facility's Registered Nurse and review of Resident #1's January 2008 Physician's Orders (POS) revealed the resident's first dose of Erythromycin Ointment was received on January 31, 2008 (fourteen days after it was prescribed). At the time of the survey, the facility failed to ensure Resident #1 received his initial dose of Erythromycin in a timely manner. 4. The facility failed to ensure Resident #1 was provided with sunscreen as recommended. Observation on May 2, 2008 at 5:50 PM revealed Resident #1 left the facility with staff and his 				processing of all physicisin a timely manner. This initiation and discontinumeds. 4-5. The QMRP and thave instructed the Manager and staff to comply sunscreen on on when he is going outside the day. Staff retraining on client of sunscreen will be 6/13	the nurse House Insistently Client #1 Ide during tt # 1 use	ongoing 6-13-08

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING			X3) DATE SURVEY COMPLETED	
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1401	housemates to go to not observed to recibefore leaving for the Review of Resident 2, 2008 at 12:15 PM 2008 Physician's Outher resident had medically for the resident had medically for the resident had medically for the resident had medically for the resident had medically for the resident had been outdoors. Interview was cond 2008 to ascertain in recommended sunst that observation of the resident for the resident's POS addicated to provide evand/or received the should be further president's POS addicated for the facility failed to provided with the readdress his medically failed to provided with the readdress his medically failed to provide with the readdress his medically failed to provide for the facility failed to provide with the readdress his medically fa	o dinner. The reside eive any topical crea	s on May ent's April cumented uding record record resident farch 14, as nscreen on May 2, noted ment and he survey ent had screen. It ne vide ordered survey, was reen to o. ng n client ing at 5:10 d each residential ministered,	! 401	5 The nurse instructed the give the topical medication they are administered with assistance after bathing. (I orders allow this assistance individual that administer topical application should that they provided the treat The nurses have been train the format of documentation is needed. 6 The nurse instructed the give the topical medicathey are administered wassistance after bathing orders allow this assistance individual that administered application shouthat they provided the treat the format of documentation is needed.	on as h staff PCP ce.) The rs the l sign atment. ned on ion that e staff to ation as with staff g. (PCP ce.) The sters the uld sign atment. ained on	6/16/08 ongoing	

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	ED
OTREST ADDRESS SITV STATE ZIP CODE				STATE ZID CODE	05/02	/2008	
NAME OF I	PROVIDER OR SUPPLIER						
CHRYSA	ALLIS			ST STREET, STON, DC 20			
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I 401	Records (MARs) for and revealed that the orders that were signored that the following revealed that the following revealed that the following revealed that the following revealed that the following revealed that the following revealed that the following revealed that the arm 6:00 PM and Protogointments were signored that the following reveals that the cream the cream the nurse but not old administration.	r each client was revolved residents had transported off as given by the medication admillowing treatments not given as evidences prescribed Hydrophis and legs every events of 0.1% ointment. Indeed off as given by the medication was signed off as given was signed off as given by the medication was signed off as given by th	eatment the nurse. inistration ed below: nor ening at The ne nurse nazole 2% iven by nedication				
	twice day (once at lotion (to be given a signed off as given during the medicati At the time of the simplement a system personnel administration of the 7. The facility's numan effective system discontinued medic implemented. Observation of the April 30, 2008 at 5: was administered in (Carbidopa/Levodo)	urvey, the facility fails that ensured nursing ered and/or monitored client's topical medications/treatments with the control of the control	on 12% vicals were observed ed to ng ed the dications to ensure as ration on resident ident #1's		7. The QMRP and client program had a meeting that the day program ad medication in compliant physician orders. The DON and the QM shall monitor more medication administration day programs to ensiphysician orders are complied with.	for ensure ministers nee with fraction with the closely on in the nure that	6-16-08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
09G161				B. WING			
				DRESS, CITY, S	STATE, ZIP CODE		
CHRYSA				T STREET, TON, DC 20			
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I 401	2008 at 12:15 PM revealed an order for Erythromycin Ophth 5mg/gm ointment to be applied to each eye every evening. The Erythromycin was not observed to be administered during the evening observation (April 30, 2008). Continued review of the POS revealed the hand written notation "D/C'd" was documented adjacent to the Erythromycin order. It should be noted that notation failed to be initialed or dated by the person that made the notation. Additionally, the printed POS had an area designed on the form for the documentation of discontinued medications. The area made provision for date, time, and person initials to be documented. Interview was conducted with the facility's Registered Nurse (RN) on May 2, 2008, to ascertain information about the Resident #1's Erythromycin. According to the RN, the medication was discontinued on March 27, 2008, the date Resident #1's April 2008 POS was signed by the physician. Review of Resident #1's Medication Administration Record on May 2, 2008, however, revealed the Erythromycin was administered until March 30, 2008. At the time of the survey, the actual discontinuation date for Resident #1's Erythromycin could not be		I 401	8. The nurse has been in to review all physician or proper signature and dati MD must sign and day notation that the MD must the physician orders and medical records. The Dimore aggressively monitor in clients' records to consistent compliance recording procedures	rders for ng. The te every nakes on d in the ON will or entries ensure	6-16-08	
I 422	determined. 3521.3 HABILITATI	ION AND TRAINING	2	1 422			
	and assistance to re the resident's India This Statute is not Surveyor: 17620 Based on observati	provide habilitation, esidents in accordan vidual Habilitation Plamet as evidenced by on interview and rec	ce with an. /: ord		As answer to 1422, the fathereby cross-references a adopts the answers to 118	ınd	ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N			A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF F					TATE, ZIP CODE		
CHRYSA	LLIS			RST STREET, GTON, DC 20			
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I 422	training and assistaresidents in accordant Habilitation Plan(s), residents (Resident the sample. The finding includes I. The facility failed services met each of (See Federal Deficional III. The facility failed received continuous including needed in Deficiency Report Continuous i	nce was provided to ance with their Indivi- for three of the thre is #1, #2 and #3) inci- s: to ensure that outsic clients active treatmetency Report Citation. If to ensure each clies active treatment set the ency Report Citation is active treatment set the ency Report Citation. If the ensure each clies active treatment set the ency Report Citation is active treatment set the ency entitled to provide evide was trained on his Eincluding the use of the ency 1, 2008 beginning the tion. The ensure that outsic including the use of the ency for the facility's TV report incidents in the ency for the sofa in the in the ency for the sofa in the in the ency for the en	dual e luded in de ent needs. W120) nt ervices, ederal nce that Behavior special client's at 5:09 ff #1) boom. At re e TV erved yor A with				
	Client #2 heading rapidly towards Surveyor A with both of his arms extended (Surveyor A's back was facing the client). Surveyor B assisted Surveyor A by moving Surveyor A out of the reach of Client #2. The client was observed to be physically aggressive and began to yell and scream. Continued observation during the aggressive						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
09G161				B. WING		05/02/2008	
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(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPL	ETE
1 422	attempted to prevent the aggression towards Surveyor A by pulling the client. Client #2 was then observed to head down the hallway towards his bedroom, but prior to getting to the hallway, Client #2 hit Surveyor A. Afterwards, Client #2 proceeded down the hallway with his 1:1 staff person holding onto his arm. At that time, the direct care staff person assigned to work with Clients #1, #3 and #6 (Staff #2) and the Qualified Mental Retardation Professional (QMRP) were observed to assist in the intervention of Client #2's behavior. The three staff were observed to have difficulty redirecting the client. They were observed to restrain both of Client #2's arms for approximately three minutes. Once the client appeared to be calm the staff escorted Client #2 outside of the facility. Interview with the QMRP on May 2, 2008 at 5:30			1 422			
	Interview with the QMRP on May 2, 2008 at 5:30 PM revealed that Client #2 had a Behavior Support Plan (BSP) that addressed behaviors of self injurious behaviors, physical aggression (such as scratching and hitting people) and throwing objects. The QMRP's statement was verified on May 2, 2008 through review of Client #2's BSP dated November 17, 2007. According to the plan, in a section entitled "Intervention Procedures for Physical Aggression," the following procedures were to be implemented: 1. If [client's name] engages in aggression, he will be given the verbal directive, "Stop [client's name]." At the time of the observation, the three staff were not observed giving a directive for Client #2 to " stop."						
	If [client's name] aggressive behavio "CPI Supportive Sta	continues displaying rs staff should assur ance" as trained in the s Intervention Progra	me the				

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	TATE, ZIP CODE			
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1 422	Interview was cond 1, 2008 at 5:30 PM regarding which statechniques to mana (CPI Supportive Statervention Technisurvey, the facility the QMRP, Staff 1 in the aforemention noted that during the evidence that the separation behaviors assumed documented in the 3. Staff should remaked things as personal away) and body po	ucted with the QMF to ascertain informal off was trained on speage inappropriate belonce and Non-Violen ques). At the time offailed to provide evide and Staff 2 had beer used techniques. It she observation there taff addressing Cliend the supportive stanclient's BSP. The consider space (remain about sture/motion (keep years).	tion ecialized havior ice Crisis f the lence that n trained ould be was no t #2's ce such t 1-3 feet our hands	1 422				
	away) and body posture/motion (keep your hands open and facing upward). At the time of the observation, the three staff were in close proximity of Client #2. Additionally, the staff's hands were not positioned as indicated in the aforementioned intervention. It should noted that all three staff were observed to restrain the client's arms. 4. In the event that the behavior escalates, staff will utilize a block technique (learned in NVCI, see instructors' Manual) to interrupt the behavior(s). At the time of the observation, the three staff were not observed to utilize/implement a block technique as recommended in Client #2's BSP.			·				
	episode three staff client's arms for ap PM - 5:30 PM). Th May 1, 2008 reveal provide evidence th	t #2's physical aggre were observed to re proximately four min e QMRP's was inter led that the facility fan hat Staff 1, Staff 2, a	strain the nutes (5:26 view on iled to nd the					

1422 Continued From page 16 used to manage inappropriate behaviors. It should be further noted that on May 2, 2008, Staff #3 was assigned to work with Client #2. Review of the facility's training record and continued interview with the QMRP failed to provide evidence that Staff 3 was trained in CPI Non-Violence Crisis Intervention Program and/or any other specialized techniques to manage inappropriate behavior. Additional interview with the QMRP on May 1, 2008, at 5:30 PM revealed Client #2's assigned 1:1 staff (Staff #1) had been employed at the facility for less than a month (since April 2008). According to the QMRP, he trained the 1:1 staff on Client #2's BSP. When requested to provide evidence of the training he conducted with the 1:1 staff, the QMRP failed to produce evidence of the aforementioned training. Review of the facility's training records on May 1, 2008 at 6:25 PM, revealed the last training on BSP's was held on January 25, 2008; Client #2's 1:1 staff was not present at that training. It should be further noted that the training sign in sheet failed to specifically identify which BSP's were reviewed. Note: Review of Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History," According to that section, Client #2' has a history of needing behavioral support. He has for some time had 1:1 staff support due to concerns regarding intense aggressive and self-injurious	1					·			
NAME OF PROVIDER OR SUPPLIER CHRYSALLIS STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020 PROVIDER'S PLAY OF CORRECTION FREENY, TAG CANDID INTERPRETATION OF PRICINGUISE (EACH CORRECTION MOST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1422 Continued From page 16 used to manage inappropriate behaviors. It should be further noted that on May 2, 2008, Stafff #3 was assigned to work with Client #2. Review of the facility's training record and continued interview with the QMRP failed to provide evidence that Staff 3 was trained in CPI Non-Violence Crisis Intervention Program and/or any other specialized techniques to manage inappropriate behavior. Additional interview with the QMRP on May 1, 2008, 31530 PM revealed Client #2's assigned 1.1 staff (Staff #1) had been employed at the facility for less than a month (since April 2008). According to the CMRP, he trained the 1.1 staff on Client #2's BSP. When requested to provide evidence of the training records on May 1, 2008 at 6:25 PM, revealed the last training on BSP's was held on January 25, 2008, Client #2's 11 staff was not present at that training. It should be further noted that the training it is should be further noted that the training it is should be further noted that the training it is should be further noted that the training it is should be further noted that the training sign in sheet failed to specifically identify which BSP's were reviewed. Note: Review of Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History," According to the April 2009 at section, Client #2's as a history of needing behavioral support. He has for some time had 1.1 staff support due to concerns regarding intense aggressive and self-injurious.	A NID DI AM DE GODDEOTION			1 '	•				
Additional interview with the QMRP on May 1, 2008, 3151 (Sizif Sassinged inappropriate behavior. Additional interview with the QMRP on May 1, 2008, 3151 (Sizif Sizif Sizif Sizif Condition to the facility for less than a month (since April 2008). According to the Winders on May 1, 2008, at 525 PM, revealed the last training in BSP's was held on January 25, 2008. Cleent #2's table to specifically identify which BSP's were reviewed. Note: Review of Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on May 2, 2008 revealed a section entitled, "Behavior History." According to that section, Client #2's BSP on Some time had 1.1 staff support due to concerns regarding intense aggressive and self-injurious.									
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behavior. According to MRDDA case manager notes, there have been historic concerns about the qualifications and training of the 1:1 staff" At the time of the survey, the facility failed to provide evidence that staff were effectively trained in the implementation of Client #1's BSP and failed to provide evidence that staff were		used to manage inashould be further not #3 was assigned to of the facility's traininterview with the Quevidence that Staff: Non-Violence Crisis any other specialize inappropriate behave. Additional interview 2008, at 5:30 PM re 1:1 staff (Staff #1) If facility for less than According to the QN on Client #2's BSP. evidence of the train staff, the QMRP fails aforementioned train training records on Note: Review of Client #2's according to the training records on Note: Review of Client #2's BSP. evidence of the staff that training records on Note: Review of Client #2's BSP. evidence as that training records on Note: Review of Client #2's BSP. evidence for the staff suregarding to that second for the staff suregarding to that second for the suregarding intense agos behavior. According notes, there have be the qualifications and At the time of the sureprovide evidence that trained in the implemental provide as a staff with the sure provide evidence that trained in the implemental provide as a staff with the sure provide evidence that trained in the implemental provide as a staff with the sure provide evidence that trained in the implemental provide as a staff with the sure provide evidence that trained in the implemental provide evidence that trained in the implemental provide evidence that trained in the implemental provide evidence that trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the trained in the implemental provide evidence that the	appropriate behaviors of the that on May 2, 2 work with Client #2. Ing record and continued in CPI and techniques to manifor. With the QMRP on May 2 and been employed a month (since April MRP, he trained the When requested to produce evidering. Review of the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the May 1, 2008 at 6:25-1 ining on BSP's was the major of the major of the major of the May 1, 2008 at 6:25-1 ining on BSP's was the major of the major of the May 1, 2008 at 6:25-1 ining on BSP's were revent #2's BSP on May notitled, "Behavior His ction, Client #2 "has all support due to concern and training of the 1:1 street, the facility faile at staff were effective that the major of the facility faile at staff were effective that the facility faile at staff were effective that the major of the 1:1 street, the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at staff were effective that the major of the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at the facility faile at	008, Staff Review bued e mand/or lage May 1, ssigned at the 2008). It 1 staff provide the facility's PM, neld on as not ther d to viewed. If 2, 2008 story." a history or some as about staff" d to ely I's BSP	1422	DEFICIENC	**		

							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL		
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I 422	Continued From pa	ge 17 tions to manage the	client's	l 422			
	inappropriate behav	vior.	ONCTIT 3				
		d to ensure staff wer b ensure Client #1's p is implemented.					
	#1 on May 1, 2008 t	49, 2) Observation opetween at 4:44 PM	and 5:43				
PM revealed the client had a piece of cloth (cloth was approximately 1" to 1 1/2" in width and 6" in length) that he placed in his mouth, on articles of							
	furniture, on the kitc It should be noted th	hen counter, and on	the floor.				
,	aforementioned obs		nember				
!	assigned to work with	th Clients #1, #3, and	d #6 was				I
	assisting the QMRP with a behavioral ep						
	Review of Client #1's approximately 7:40 F	s record on May 2, 2	:008 at				
i	"Standard Procedure	e" dated April 10. 20	07 that				
:	addressed the client	s clothe chewing. A	According				
1	to the section entitle			i			:
	be supplied cloth pie	eces to chew on that	were "at				
į	least 6" X 6" so that						
	his mouth if he starts one up." The plan fu						!
	"once he has chewe						
	a while, it should be						
							<u> </u>
İ	should be offered a new one. When he gives up the old one and gets a new one, staff should						
	verbally praise him. Every fifth time he						ļ [
	exchanges the old chewed up cloth for a new						
ĺ	one, staff should also give him an edible reward,						į .
	that is consistent with his diet." At the time of the						i
	survey, the facility fa						;
	available/trained to a						
	#1 making certain his conducted in a safe :						[
	conducted in a sate :	and samiary manner	Loee :				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
09G161		B. WING _		05/02/2008				
NAME OF PROVIDER OR SUPPLIER STREET AD				DDRESS, CITY, STATE, ZIP CODE				
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(X4) ID PREFIX TAG				ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
1 422	Continued From page 18			1 422	As answer to 1434, the	facility		
	Federal Deficiency Report Citation W149, 2)				responds as follows:	, ,		
l 434	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (d) Dressing (including purchasing, selecting, and access to clothing); This Statute is not met as evidenced by: Surveyor: 17620 Based on observation, interview and record review, the facility failed to ensure residents were effectively trained in the area of privacy, for two of the three (Residents #1 and #3) included in the sample.			1434	client # 3 while bathroom because c fainted while using the	1. Staff is instructed to monitor client # 3 while using the bathroom because client # 3 fainted while using the bathroom in 2007 and was taken to hospital, treated and discharged. However, the facility will conduct further staff training on client		
					treated and discharged. However, the facility v			
:					privacy rights and protection to ensure a reasonable balance between monitoring client # 3 and the need to protect his privacy at all times. 2. When client # 2 went into an		ongoing	
;	The findings include 1. Observations cor 4:36 PM revealed R assistance while usi resident was observ the bathroom door of	nducted on May 2, 2 esident #3 received ng the bathroom. Tl ed seated on the toi	staff ne let with		explosive behavior an attack a surveyor in the emergency situation. The staff assigned to turned to provide assigned to emergency situation to	emerged. client # 1 stance in an		
	survey the facility fai right to privacy was care.	led to ensure the res	sident's		surveyor from being mere reflex action on the staff with the	hit. It was the part of	6/4/8 ongoing	
	2. Observation of R 5:46 PM, revealed F with his buttocks exp (pants down). Resident #1 believision room throubuttocks still expose accompanying them	Resident #1 was obs bosed in the television dent #4's 1:1 attempt y escorting him from ugh the dining room d and Resident #4	erved on room red to n the (with his		ensuring safety of Unfortunately, within time client # 1 pa pulled and expunderwear. However, the staff and other staff members.	this short nt partially osed his in question		
	noted that at the time observation, the staf	e of the aforementio	ned !		retrained on privacy protection of client #	right and		
ealth Regula FATE FÖRM	tion Administration I		61	⁸⁹⁹ 31	other clients in the f staff will also be retra to respond in an	ined on how	sheet 19 of 20	

situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
09G161			B. WING		05/02/2008				
				DRESS, CITY, STATE, ZIP CODE					
			ST STREET, SE GTON, DC 20020						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE			
1 434	I 434 Continued From page 19			1 434					
	with Residents #1, #3 and #6 was assisting the QMRP and another staff member with a behavioral episode involving Resident #2. At the time of the survey, the facility failed to ensure Resident #1's right to privacy during dressing.								
I 500	3523.1 RESIDENT'S RIGHTS			1 500					
	Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.				In response to 1500, please reference responses to Federal Deficiency Report Citations W 102, W122, W124 and W158.				
	Surveyor: 17620 Based on observation	met as evidenced by on, interview and rec railed to ensure the client's rights.	ord			:			
	The findings include:								
	(See Federal Deficie W122, W124, and V	ency Report Citation: W158)	s W102,						
			-						
 - - - -						!			
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